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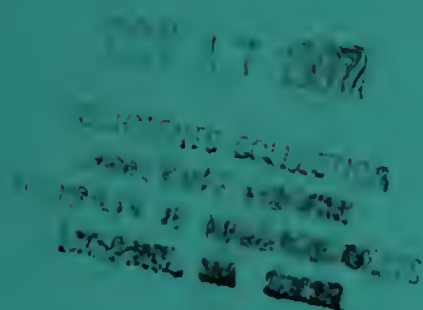
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Serving Health Information Needs of Elders (SHINE) Program

of the
Massachusetts Executive Office Of Elder Affairs

SHINE Resource Manual

1996 Edition



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Serving Health Information Needs of Elders
SHINE Resource Manual

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SHINE -SERVING HEALTH INFORMATION NEEDS OF ELDERS

TOPICS:

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INTRODUCTION:

It is a well known fact that many elders have difficulty understanding the complex and constantly changing health care system. As a result, older Americans often have questions about health insurance, but, all too frequently have limited resources to obtain objective information. Many elders are in need of help and advice in deciding what kinds of benefits would suit their needs, the amount of health insurance coverage they should have, and how to take full advantage of the cover they already have. With many insurance companies specializing in selling Medicare supplements, long-term care insurance, and other insurance products to a rapidly growing segment of the older adult population, and with the ever-changing Medicare system, many elders are confused and vulnerable. Untold dollars are being wasted by consumers as a result of complex, confusing or inaccurate information about health insurance coverage, claim procedures and beneficiary rights.

HISTORY:

In 1985, in response to this problem, the Massachusetts Executive Office of Elder Affairs (Elder Affairs) started the Serving Health Information Needs of Elders (SHINE) Program. It was initially tested in three pilot sites for two years before expanding the Program to eight Regional Programs in 1988. The Regional SHINE Programs are administered in partnership with local Councils on Aging and Area Agencies on Aging and provide services at the local level in almost every community in the state.

In October of 1992, Elder Affairs received a federal grant from the Health Care Financing Administration (HCFA) under the Health Insurance Information,

Counseling and Assistance Grant Program. The grant allowed Elder Affairs to expand the Program statewide. Now, 17 Regional SHINE Programs provide information, counseling and assistance services to Medicare beneficiaries and senior citizens throughout Massachusetts.

PROGRAM DESCRIPTION:

The SHINE Program is a network of elder volunteer health benefit counselors who have been trained and certified by the Executive Office of Elder Affairs to provide information, counseling and assistance regarding health insurance and benefits to elders and their family members. The counselors work in Senior Centers, Councils on Aging, Area Agencies on Aging, Home Care Corporations, community hospitals and many other community-based sites. Services are also provided to homebound and handicapped elders.

GOALS:

The objective of the SHINE Program is to provide Massachusetts elders with access to accurate, unbiased health insurance information, counseling and assistance free of charge through a network of trained health benefit counselors.

ADMINISTRATIVE STRUCTURE:

EXECUTIVE OFFICE OF ELDER AFFAIRS/SHINE PROGRAM

SHINE Program Director and SHINE Program Specialists

REGIONAL COORDINATING/LEAD AGENCY

**SHINE Regional Coordinator, Administrative Volunteers
and SHINE Counselors**

REGIONAL MEMBER AGENCIES

SHINE Counselors

SHINE SERVICES:

Provide information about:

- Medicare
- Medicare Supplemental Insurance
- Health Maintenance Organizations (HMOs)
- Medicaid, QMB, & SLMB
- Long Term Care Medicaid
- Long Term Care Insurance
- Supplemental Security Income (SSI)
- Free Hospital Care Pool
- Free Prescription Drug Program
- Insurance Claims Processing
- Medicare Appeals and HMO Grievance Procedures

Counsel elders on many topics, including:

- How to compare health insurance options (Medigap & HMOs)
- How to check one's existing plans for duplicate coverage
- One's rights to receive written notice when Medicare coverage will be denied or is ending
- How to file a complaint on an insurance company
- How to locate a "Medicare Participating provider"

Provide assistance with

- Application process for public benefits
- Filing Claims for reimbursement of out of pocket payments
- starting an Appeal or using an HMO grievance process
- Contacting Social Security or the Carrier to get up to date information

TRAINING:

Elder Affairs SHINE staff provide the initial certification and recertification training. Thereafter, Regional Coordinators provide ongoing supervision and assistance on cases, and monthly updates and training exercises to counselors. Counselors report their work and problems to the Regional Coordinator who is responsible for supervising and monitoring their work.

ACHIEVEMENTS:

Over the past nine years SHINE has gone through much growth and development, making it a national leader among health insurance counseling programs. It is particularly proud of the achievements of its 410 volunteers counselors. During 1995, SHINE counselors assisted more than 37,000 individuals and saved approximately \$3.6 million dollars on their behalf.

Other SHINE achievements include:

- o Receipt of the Health Care Financing Administration's Medicare Beneficiary Service Award for 1990.
- o Founding Member of the HCFA's Partnership for Health Insurance Counseling Development Group.
- o Receipt of grant award from the HCFA under the Health Insurance Information, Counseling and assistance Grants Program.
- o 1994 National Beneficiary Services Award given to EOEA SHINE Hotline Counselor Robert Carey for his outstanding achievements in service to Massachusetts Medicare beneficiaries.
- o Election of the SHINE Director to serve on the National Health Insurance Information, Counseling and Assistance Steering Committee which oversees the development of standards and policies for the improvement of all ICA programs across the nation as well as the development of the National ICA Resource Center in Washington, DC.

ACRONYMS FOR MEDICARE AND HEALTH INSURANCE

ALJ	- Administrative Law Judge
BHA	- Bureau of Hearings and Appeals
DHHS	- Department of Health and Human Services
DRG	- Diagnostic Related Groups
EOEA	- Executive Office of Elder Affairs
EOMB	- Explanation of Medicare Benefits
ESRD	- End Stage Renal Disease
HCC	- Home Care Corporation
HCFA	- Health Care Financing Administration
HHA	- Home Health Agency
HMO	- Health Maintenance Organization
LTCU	- Long Term Care Unit of Medicaid
LTCI	- Long Term Care Insurance
NDG	- Network Design Group
PPS	- Prospective Payment System
PRO	- Peer Review Organization
QMB	- Qualified Medicare Beneficiary Program
RRB	- Railroad Retirement Board
SLMB	- Specified Low-Income Medicare Beneficiary Program
SHINE	- Serving Health Information Needs of Elders Program
SNF	- Skilled Nursing Facility
SSA	- Social Security Administration
SSI	- Supplemental Security Income

GLOSSARY OF TERMS

Activities of Daily Living (ADLs) - Activities which include help walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. Also see "Custodial Care."

Actual Charge - The amount a physician or other health care provider bills a patient for a particular medical service or procedure. The actual charge may differ from the Medicare approved amount or amount approved by other insurance programs.

Acute Hospital - A hospital which provides care for persons who have a crisis, intense or severe illness or condition which requires urgent restorative care.

Appeal - Medicare beneficiaries have the right to request a review of a denied claim, and if not satisfied with the review, to appeal to a higher review. See Medicare Appeal.

Approved Charge - The maximum fee that Medicare or other insurers will use in reimbursing a provider for a given services or piece of equipment.

Area Agencies on Aging (AAA) - Local government agencies which grant or contract with public and private organizations to provide services for older persons within their area.

Assignment - The physician or supplier who accepts assignment under Medicare Part B agrees to accept Medicare's approved charge as payment in full. If so, Medicare will pay 80 percent to the doctor. The doctor can bill the patient for the loss of insurance, plus the \$100 Part B deductible, if applicable.

Beneficiary - Any person who receives benefits.

Benefit Maximum - The limit a health insurance policy will pay for a certain loss or covered service. The benefit can be expressed either as 1) a length of time (for example, 60 days), or 2) a dollar amount (for example, \$350 for a specific procedure or illness), or 3) a percentage of the Medicare approved amount. The benefits may be paid to the policyholder or to a third party. This may refer to specific illness, time frame, or the life of the policy.

Benefit Period - This is the period of time for which payments for benefits covered by an insurance policy are available. The availability of certain benefits may be limited over a specified time period.

Benefit Period under Medicare - A Medicare benefit period begins upon entry to a qualified hospital and ends when the patient has been out of a hospital and not receiving Medicare benefits in a facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days, including the day of discharge.

Biological - Substances, such as whole blood, hemophilia clotting factors, tetanus antitoxins vaccines, tumor chemotherapy agent, etc.

Buy-In Program - in which the state's Medicaid program pays the Medicare premiums, deductibles and co-payments for certain low income eligible people.

Calendar Year - January 1 through December 31.

Carrier - A health insurance company under contract with the Health Care Financing Administration (HCFA) to handle claims processing for Medicare Part B.

CHAMPUS - Civilian Health and Medical Program of The Uniformed Services - relating to auxiliary medical services for active/retired military and their dependents.

Charges - Prices assigned to units of medical service, such as a visit to a physician or a day in the hospital. Charges for services may not be related to the actual costs of providing the services. Further, the methods by which charges are related to costs vary substantially from service to service and from institution to institution.

Chronic - A lasting, lingering or prolonged illness.

Claim - A bill requesting that medical services be paid by Medicare or by some other insurance company.

COBRA Legislation - From the Consolidated Omnibus Budget Reconciliation Act. Law requires that employees, spouses of employees and dependents who would otherwise lose membership in the employer group health plan, due to loss of

employment or death or divorce of employee, be permitted to extend their health coverage for up to 36 months.

Conditional Enrollment - For persons who are not already enrolled in Medicare Part A and choose to enroll only if qualified for the State payment of deductible, they can apply for a conditional enrollment. If not qualified, enrollment will not occur. Also see "Qualified Medicare Beneficiaries, QMB's."

Conditionally Renewable - This company agrees to continue to insure you contingent upon certain specified conditions.

Conservatorship - A legal procedure by which one person, the conservator, is given power over the living arrangements, property and/or finances, of another person, the conservatee. Conservatorship is established with legal safeguards for the person who needs help.

Coordination of Benefits - Provisions and procedures used by insurers to avoid duplicate payments for losses insured under more than one policy. One of the insurers is usually the primary payer, who assures that no more than 100% of the costs are covered. This does not usually apply to indemnity (cash payment) policies. Also see "Medicare as Second Payer."

Co-payment - A specified dollar amount or percentage of covered expenses which the beneficiary is required to pay towards medical bills. Medicare Part A Hospital Insurance requires that a copayment, or co-insurance, is paid by the beneficiary for certain covered services, and the 21st through the 100th day of skilled nursing facility care. Medicare Part B pays 80% of "approved" charges and the beneficiary must pay the 20% and the balance of the charges.

Costs - Expenses incurred in the provision of services or goods. Charges billed to an individual or third party may not necessarily be the same. Hospitals often charge more for a given service than it actually costs in order to recoup losses incurred from providing other services where costs exceed feasible charges.

Covered Services - Medicare law permits payment only for services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury." Therefore,

Medicare can pay for services only as long as they are medically necessary.

CPT- "Physicians' Current Procedural Terminology", Copyright 1990 by the American Medical Association. (Preceded in use by the CPT-4, fourth edition.) A listing of the descriptive terms and the numeric identifying codes and modifiers for describing and reporting medical services and procedures performed by physicians. These codes are required on the Request for Medicare Payment form for claims submitted for Medicare payment.

Custodial Care - Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine,. (These may also be referred to as Activities of Daily Living or ADLs.)

Deductible - An initial amount of medical expense for which the beneficiary is responsible before Medicare or an insurance policy will pay.

DHHS - Department of Health and Human Services (Federal)

Diagnosis Related Groups (DRGs) - DRGs are used to determine the amount that Medicare reimburses hospitals for in-patient services. It is part of the Prospective Payment System. Categories of illnesses are divided into 477 groups, one of which is assigned to a Medicare patient being discharged from a hospital. The hospital is reimbursed a fixed amount based on the DRG code for the patient.

Duplication of Coverage - Coverage of the same health services by more than one health insurance policy.

Durable Medical Equipment (DME) - Durable medical equipment is equipment which can 1) withstand repeated use, 2) is primarily and customarily used to serve a medical purpose, 3) generally not useful to a person in the absence of an illness or injury, and 4) is appropriate for use in the home.

Durable Power of Attorney for Health Care/"Health Care Proxy"

In this legal document. a "principal" (the person giving the power to decide to

another) authorizes the "proxy" (the person given the power to make decisions) to make decisions regarding the principal's medical treatment when or if the principal becomes unable to communicate his/her choices. It can be revoked at any time.

Duration of Benefits - Time period or maximum amount of dollars for which an insurance policy will pay benefits.

Elimination Period - It is the number of days before any benefit will be paid. (Also known as a deductible period or a waiting period)

End Stage Renal Disease (ESRD) - Medical condition in which a person's kidneys no longer function, requiring the individual to receive dialysis or a kidney transplant to sustain his or her life.

Enrollment - Procedure by which eligible persons can sign up for the Medicare program and receive Medicare coverage. It is handled by the Social Security Administration through local Social Security offices.

Enrollment Period - Period during which individuals may enroll for an insurance policy, Medicare, or Health Maintenance Organization (HMO) benefits.

Entrance Age - The maximum or minimum age at which a company will sell the policy.

Exclusion - An expense or condition that the policy does not cover and toward which it will not pay. Common exclusions may include pre-existing conditions, such as heart disease, diabetes, or hypertension. Because of such exclusions, persons who have a serious condition or disease are often unable to secure insurance coverage, either for general conditions or the particular disease. Sometimes excluded conditions are excluded only for a defined period after coverage begins.

Explanation of Medicare Benefits (EOMB) Forms - The statement that the Medicare carrier sends the beneficiary to show what action was taken on the claim. If payment is being issued to the Medicare beneficiary, a check will be attached. Most Medigap policies pay claims based on the EOMB.

Fee for Service - Method of charging whereby a physician or other practitioner bills for each encounter or service rendered. This is the usual method of billing by the majority of physicians.

Fee Schedule - A listing of accepted charges or established allowances for specified medical, dental or other procedures or services.

Fiscal Year (FY) - The Federal Government's budget (or fiscal) year runs from October 1 to September 30 of the following calendar year.

Grace Period - A specified period, usually 30 days, during which a premium payment is due on an insurance policy, in which the policyholder may make such payment, and during which the provisions of the policy continue.

Group Insurance - A group policy is a written contract between an insurer and employer or group, which provides benefits to the insured group members who hold individual certificates of insurance. The certificates state the provisions of the coverage given to each insured individual or family.

Guaranteed Renewable - The insurance company agrees to continue insuring the policyholder for as long as the premium is paid. The premiums for the policy cannot be raised because of the benefits received; but premiums can be raised for all policyholders.

Health and Human Services, Department of - An executive department of the federal government which has the ultimate authority for the Medicare and Medicaid programs.

Health Care Financing Administration (HCFA) - A branch of the Department of Health and Human Services, this federal agency is responsible for administering the Medicare and Medicaid programs.

HCFA-1490S - Called the Patient's Request for Medical Payment, this claim form is used by beneficiaries to submit Part B Medicare claims for medical services received prior to September 1, 1990.

Health Insurance Claim Number (HIC) - The unique alpha numeric Medicare entitlement number assigned to a Medicare beneficiary and which appears on the Medicare card.

Health Maintenance Organization (HMO) - An organization that, for a prepaid fee, provides a comprehensive range of health maintenance and treatment services (including hospitalization, preventive care, diagnosis, and nursing). Some HMOs contract with HCFA to provide health care insurance to Medicare beneficiaries. HMOs may be sponsored by large employers, labor unions, medical schools, hospitals, medical clinics, and even insurance companies. Development of HMOs was spurred by the federal government in the 1970's as a means to correct the structural, inflationary problems with conventional health care payment systems.

Home Health Agency - A home health agency is a public or private agency that specializes in giving skilled nursing services, home health aides, and other therapeutic services, such as physical therapy, in the home.

Home Health Care - Health care services provided in the home on a part time basis for the treatment of an illness or injury. Medicare pays for home care provided to homebound Medicare beneficiaries only if the type of care needed is skilled and required on an intermittent or part-time basis.

Hospice - A hospice is a public agency or private organization that primarily provides pain relief, symptom management, and supportive services to terminally ill people and their families in the home.

Illegal Sales Practices - Sales techniques used by insurance agents selling health insurance to supplement Medicare (Medigap) in which they mislead older adults into buying unnecessary coverage or paying premiums for no coverage.

Indemnity Policy - Type of insurance policy which pays a fixed amount per day for covered services received, generally a fixed amount per day of covered hospitalization.

Individual Health Insurance - Individual policy of insurance is a written contract between an insurance company and an insured person.

Initial Enrollment Period - The seven months surrounding a person's 65th birth month in which one may enroll into Medicare. Unless one is covered through an employee plan, the initial enrollment period is generally the best time to enroll.

Inpatient - A person who has been admitted at least overnight to a hospital or other health facility for the purpose of receiving a diagnosis, treatment, or other health services.

Institutionalization - Admission of an individual to an institution, such as a nursing home, where he or she will reside for an extended period of time or indefinitely.

Insured - The individual or organization protected in case of loss under the terms of an insurance policy.

Insurer - A company which agrees to reimburse the insured for a loss covered by an insurance policy in exchange for a set premium.

Intermediary or Fiscal Intermediary (FI) - Private health insurance company under contract with the Health Care Financing Administration (HCFA) to handle claims processing for Medicare Part A.

Intermediate Care Facility (ICF) - An ICF provides health related care and services to individuals who do not require the degree of care or treatment given in a hospital or skilled nursing facility, but who (because of their mental or physical condition) require care and services which is greater than custodial care and can only be provided in an institutional setting.

Length of Stay - The time a patient stays in a hospital or other health facility.

Lifetime Maximum - The maximum dollar amount that a policy will pay in the policy holder's lifetime.

Lifetime Reserve - Medicare Part A provides an extra 60 lifetime reserve days beyond the 90th day of hospital coverage in a benefit period. This is not renewable and a co-payment is required.

Loading Up - Selling two or more health insurance policies when one is adequate. It is usually the result of unscrupulous sales practices. Also called "stacking."

Long Term Care (LTC) - The medical and social care given to individuals who have severe chronic impairments over a long period of time. Long term care can consist of care in the home, by family members assisted with voluntary or employed help (such as provided by home health care agencies), adult day health care, or care in institutions.

Long Term Care Insurance - A policy designed to help alleviate some of the costs associated with long term care. Often, benefits are paid in the form of a fixed dollar amount (per day or per visit) for covered LTC expenses. Policies may exclude or limit certain conditions from coverage.

Limited Policy - Type of insurance policy which only pays benefits for a specific type of illness or health care services named in the policy.

Loss - The basis for a claim under an insurance policy. In health insurance, loss refers to expenses incurred resulting from an illness or injury.

Loss Ratio - The amount that an insurer has paid out on claims (loss) versus the premiums paid in: usually indicated as "x" cents (paid out) per dollar (collected).

Mammogram - The X-ray of the breast to diagnose breast cancer.

Medically Necessary - Medical necessity must be established (via diagnostic and/or other information presented on the claim under consideration) before the carrier or insurer will make payment.

Medicare - Title XVIII of the Social Security Act, federal health insurance program for people 65 and older and some under 65 who are disabled. Medicare has two parts. Part A is Hospital Insurance and primarily provides coverage for inpatient care. Part B is Medical Insurance and provides limited coverage for physician services and supplies for the diagnosis and treatment of illness or injury.

Medicare Appeal - Procedure by which a beneficiary who disagrees with the amount of Medicare Part B reimbursement can challenge the Medicare carrier within six months of the date of the EOMB. If dissatisfied with the decision for an amount over \$100, a beneficiary may request a hearing by an Administrative Law Judge within 60 days. Medicare Part A appeals have a 60 day time limit.

Medicare Benefit Notice - Form a Medicare beneficiary receives from the intermediary explaining Part A benefits used and the status of deductible and coinsurance.

Medicare as Secondary Payer - Situations, defined by law, in which Medicare payment may be made only after another source has either paid or denied payment of medical items and/or services.

Medicare Supplemental Policy (Medigap) - Type of insurance policy with coverage specifically designed to pay the major benefit gaps in Medicare (deductibles and co-payment).

MEDPARD - Medicare Participating Physicians and Suppliers Directory. Directory issued by the carrier listing all Medicare participating Part B providers.

National Association of Insurance Commissioners (NAIC) - The organization that prepares model provisions and guidelines for insurance companies and state legislatures.

Notice of Non-Coverage- A Medicare beneficiary may become liable for costs of hospital care after he/she is given a written Notice of Non-Coverage. This notice of noncoverage states that in the hospital's opinion and with the attending physician's or PRO's concurrence, the beneficiary no longer requires inpatient hospital care. Liability begins on the third day after the receipt of this notice from the hospital. Medicare beneficiaries can appeal written denials of coverage through an expedited appeal to the MassPRO or through the usual Medicare Part A Appeals procedure.

Nonparticipating Facility - Health care facility which does not participate in the Medicare program.

- Nursing Home** - Also convalescent hospital. A place where persons reside who need some level of medical assistance and/or assistance with activities of daily living. A term used to cover a wide range of institutions, including Skilled Nursing Facilities, Intermediate Care Facilities and Custodial Care Facilities. Not all nursing homes are Medicare approved/certified facilities.
- Nursing Home Policy** - Type of limited health insurance policy which generally pays indemnity benefits for medically necessary stays in nursing facilities (also referred to as Long Term Care policies).
- Occupational Therapy** - Activities designed to improve the useful functioning of physically and/or mentally disabled persons.
- Older Americans Act** -(OAA) Federal legislation enacted in 1965 to provide money and direction for a multitude of services designed to enrich the lives of senior citizens, (for example, adequate housing, income, employment, nutrition and health care).
- Ombudsman** - A "citizens' representative" who protects a person's rights through advocacy, providing information and encouraging institutions or agencies to respect citizens' rights.
- Open Enrollment** - A period when new subscribers may elect to enroll in a health insurance plan or HMO.
- Out-of-Pocket Expenses** - Costs borne directly by the patient without benefit of insurance; direct costs.
- Out-of-State Group Policies** - The group policy holder is not located in this state. These policies are regulated by the laws of the state in which the policy was issued rather than this state's law.
- Outlier Case** - Outlier cases are atypical cases which involve longer hospital stays or higher treatment costs. The Medicare beneficiary does not incur an obligation to pay the hospital in an outlier case.

Outpatient - A patient who receives care at a hospital or other health facility without being admitted to the facility. Outpatient care also refers to care given in organized programs, such as outpatient clinics.

Participating Facility - Health care facility which participates in the Medicare program and accepts Medicare payment for services received in the facility.

Participating Physicians/Supplier Agreement - An agreement, by an individual physician or supplier, to always accept assignment on claims for Medicare covered items and services. This agreement is valid for the calendar year and may be renewed annually. Always use a current MEDPARD when looking for a participating physician.

Peer Review Organization (PRO) - Organization paid by the federal government to review hospital treatment of Medicare patients. A patient has the right to appeal to a PRO if there is a question about care or length of stay.

Personal Care - Assistance provided to people who need help with bathing, cooking, dressing, eating, grooming or personal hygiene. These services are not routinely paid for by either Medicare or Medicaid.

Personal Comfort Items - For hospital inpatients, such items as a television, telephone, etc.

Physical Therapy - Services provided by specially trained and licensed physical therapists in order to relieve pain, restore maximum function, and prevent disability, injury or loss of body part.

Power of Attorney - A legal document which gives a "proxy" (usually a spouse, or other relative or friend) the power to act on behalf of the "principal" (the person appointing the proxy). The principal must be competent when this appointment is made. Also, the principal does not lose his/her legal right to act on his own behalf.

Pre-existing Condition - Health conditions or problems that were identified and treated before health insurance was purchased. The definition and waiting period before these conditions are covered varies from policy to policy. However, there is a

maximum six month waiting period for Medigap policies. Usually, treatment must have been received in the preceding six to twelve months for the condition to be considered "pre-existing".

Premium - Dollar amount paid periodically (monthly, quarterly, or yearly) by an insured person or policyholder in exchange for a designated amount of insurance coverage.

Prior Authorization - Approval may be required before a medical service is provided. For procedures which require prior authorization, an insurer can deny coverage for services already provided or for proposed services which are deemed to not be medically necessary. It is generally the responsibility of the consumer to obtain the prior authorization.

Primary Payer - Insurer that pays first.

Prospective Payment System (PPS) - A standardized payment system implemented in 1983 by Medicare to help manage health care reimbursement whereby the incentive for hospitals to deliver unnecessary care is eliminated. Under PPS, hospitals are paid fixed amounts based on the principal diagnosis for each Medicare hospital stay. In some cases the Medicare payment will be more than the actual cost of providing services for that stay; in other cases, the payment will be less than the hospital's actual cost. In special cases, the hospital may receive additional payment for unusually high costs. Also see "Outlier Cases."

Provider - Someone who provides medical services or supplies, such as a physician, hospital, x-ray company, home health agency, or pharmacy.

Qualified Medicare Beneficiary Program (QMB's) - A federally required program in which States are required to pay the Medicare premiums, deductibles and co-payments for Medicare beneficiaries who have limited income and assets.

Railroad Retirement - Persons who worked for a railroad company are entitled to their benefits at retirement (includes Medicare).

Reasonable and Necessary Care - The amount and type of health services generally accepted by the health community as being required for the treatment of a specific disease or illness.

Reconsideration - The first step in the Medicare Part A appeal process. Beneficiary sends a written request to the intermediary showing his or her disagreement with the Part A payment allowed for claim and asks that the payment decision be reviewed.

Renewable at Company Option - A right reserved by the insurance company to stop insuring an individual, but the company cannot stop paying benefits provided by the policy in the midst of an illness.

Respite Care - Services designed to provide temporary relief to an at-home care giver.

Review - The first step in the Medicare Part B appeal process. Beneficiary sends a written request to the carrier showing his or her disagreement with the Part B payment allowed for a claim and asks that the payment decision be reviewed.

Rider - A legal document which modifies the protection of an insurance policy, either extending or decreasing its benefits, or which adds or excludes certain conditions from the policy's coverage.

Secondary Payer - A payer of health benefits whose payments cannot be made until another primary party has processed the claim and issued a claim determination.

Skilled Nursing Care - Care which can only be provided by or under the supervision of licensed nursing personnel.

Skilled Nursing Facility - A Medicare approved skilled nursing facility which is staffed and equipped to furnish skilled nursing care, skilled rehabilitation services and other important related health services for which Medicare pays benefits.

Specified Low-Income Medicare Beneficiary Program

Program requires State to pay the Part B premium for low-income Medicare beneficiaries.

Social Security Administration (SSA) - A branch of the Department of Health and Human Services which is responsible for determining the Medicare eligibility and the Medicare enrollment process.

Specific Disease Policy - Type of limited health insurance policy which only covers the expenses incurred for the specific disease named in the policy. The most common type is cancer insurance.

Speech Therapy - The study, examination, and treatment of defects and diseases of the voice, speech, spoken and written language.

Spousal Impoverishment Law - If one member of a married couple becomes a nursing home resident, the property and assets of the married couple will be combined, regardless of who owns the asset, and divided in half, according to HCFA standards. This process protects the community spouse from becoming impoverished. The division of marital assets can be appealed by the community spouse under certain conditions.

SSN- Social Security Number

Supplemental Security Income (SSI) - A federal program that pays monthly amounts to low income aged persons, 65 years or older, or blind or disabled low income persons of any age. Eligibility criteria include having limited assets.

Suppliers - Persons or organizations, other than physicians or health care facilities, that furnish medical equipment or services, such as ambulance firms, laboratories, and equipment rental outlets.

Third Party Liability - A party other than a beneficiary who is responsible for payment of part or all of a specific Medicare claim. Medicare supplemental insurance (Medigap) coverage is one example.

Title XVIII - That portion of the Social Security Act which clearly defines the provisions of Medicare.

Title XIX - That portion of the Social Security Act which clearly defines the provisions of Medicaid.

Twisting - The insurance sales practice of replacing an existing health insurance policy with a new one from a different company in order to receive the lucrative first-year sales commission.

Unassigned Claim - A claim on which the doctor or supplier refuses to accept Medicare's approved charge as payment in full.

Underwriting - The process by which an insurer establishes and assumes risks according to insurability.

Usual, Reasonable, Customary Charges - In "insurance language" this is the maximum amount a company will pay on a claim as determined by their guidelines. (Similar to Medicare's "approved charge".)

Utilization Review Committee - Committee in a health care facility or HMO which evaluates the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. This includes a current and retroactive review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices.

VA - Veterans' Administration (Federal)

Visit - An encounter between a patient and a health care professional which requires either the patient to travel from his home to the professional's usual place of practice (an office visit), or for the doctor or other health care provider to see the patient in the hospital, skilled nursing facility, or in the patient's home. Doctors' services can be covered in any of these settings under Medicare.

Waiting Period - The period of time that must pass after becoming insured before the policy will begin to pay benefits for a preexisting condition or certain specified illness.

CHAPTER 1

MEDICARE

OBJECTIVES OF THIS SECTION:

- * Introduce you to the basic workings of Medicare;
- * Review Medicare eligibility requirements and public benefit programs for low-income seniors, such as Medicaid, the Qualified Medicare Beneficiary Program, and the Specified Low-Income Medicare Beneficiary Program.
- * Explain the meaning of key words and phrases relating to Medicare.
- * Describe the key features of Medicare benefits for Plan A (Hospital) and Plan B (Medical) coverage.

WHAT YOU NEED TO KNOW:

1. Who is eligible for Medicare
2. When and How to enroll into Medicare Part A or Part B:
 - 65 and retired
 - 65 and still working
 - disabled under age 65
 - persons with end-stage renal disease
3. What are the benefits and limitations of Medicare Part A Hospital Coverage?
4. What are the benefits and limitations of Medicare Part B Medical Coverage?
5. Eligibility for Qualified Medicare Beneficiary (QMB) Program and the Specified Low-Income Beneficiary (SLMB) Program.

MEDICARE COSTS AND CO-PAYMENTS 1997

MEDICARE PART A (HOSPITAL)

MONTHLY PREMIUM: * \$311 or \$187

HOSPITAL DEDUCTIBLE: \$760 for first 60 days

HOSPITAL CO-PAYMENTS:

\$190/day for 61st to 90th day

\$380/day for 91st to 150th day

SKILLED NURSING FACILITY CO-PAYMENTS:

\$95.00/day for 21st to 100th day

HOME HEALTH CARE CO-PAYMENTS:

20% of approved amount for durable medical equipment

HOSPICE CARE COSTS/BENEFITS:

Limited costs for outpatient drugs and respite care.

BLOOD (Part A or B): For first three pints

* **NOTE:** Most people do not pay a premium for Part A because they or their spouse paid into the Social Security trust fund. But some people 65 or older do not meet the requirements for premium-free Hospital Insurance (Part A). People in this category can "purchase" Part A by paying a monthly premium. This is called "premium hospital insurance."

In 1997, if you have less than 29 quarters of Social Security coverage, your Part A premium will be \$311 a month. If you have 30 to 39 quarters of Social Security coverage, your part A premium will be \$187 per month. Premium amounts change each January.

MEDICARE COSTS AND CO-PAYMENTS

1997

MEDICARE PART B (MEDICAL)

MONTHLY PREMIUM: \$43.80

MEDICAL EXPENSES DEDUCTIBLE: first \$100 of approved medical service costs in each calendar year

MEDICAL EXPENSES COPAYMENT:

20% OF APPROVED AMOUNT (after meeting the Part B deductible) and PERMISSIBLE EXCESS CHARGES ABOVE APPROVED AMOUNT (amount varies by providers)

CLINICAL LABORATORY SERVICES:

Beneficiary pays nothing for approved services.

HOME HEALTH CARE:

20% of approved amount for durable medical equipment (after meeting the Part b deductible).

OUTPATIENT HOSPITAL TREATMENT:

20% of billed amount (after meeting Part B deductible)

BLOOD (Part B):

First three pints plus 20% of approved amount for additional pints (after meeting Part B deductible).

MEDICARE OVERVIEW

GENERAL INTRODUCTION TO MEDICARE

Medicare is a federal health insurance program for people 65 or older and some disabled people under 65. Medicare was enacted into law in 1965, Title XVIII of the Social Security Act, and became effective July 1, 1966.

The program was the first large federal health insurance program enacted by the United States government. It was a part of Lyndon B. Johnson's Great Society Program.

Medicare is not a comprehensive health insurance program. It was never intended to pay 100% of health care costs.

- It forms the foundation for the retiree's protection against heavy medical expenses.
- There are "gaps" in Medicare where the beneficiary must pay a portion of medical expenses.

A person is eligible for Medicare if they are eligible to receive a Social Security pension and are aged 65 years of age or older, or if they receive Social Security disability payments for 24 months.

MEDICARE HAS TWO PARTS: Part A is "hospital insurance"; Part B is "medical insurance."

Medicare Part A is primarily an acute care program. Part A helps pay for:

- * inpatient hospital care,
- * some care in a skilled nursing facility,
- * home health care,

- * hospice care, and
- * blood

Medicare Part B helps pay for medically necessary:

- * physician's services,
- * outpatient hospital services,
- * durable medical equipment,
- * home health care (if not covered under Part A).
- * blood

ADMINISTRATION

The agencies in charge: The United States Department of Health and Human Services (DHHS) is the agency that administers the Medicare Program through its divisions, the Social Security Administration (SSA) and the Health Care Financing Administration (HCFA). However, it is **ultimately controlled by the U.S. Congress.**

DEPARTMENT OF HEALTH AND HUMAN SERVICES(DHHS)	
HEALTH CARE FINANCING ADMINISTRATION (HCFA)	SOCIAL SECURITY ADMINISTRATION (SSA)

Determines policy

Processes Medicare applications

Budgets for Medicare

Issues Medicare Card

Issues Regulations

Provides Public Information

Sets provider fees

Determines eligibility for
Medicare

Contracts with carriers and intermediaries.

With states, administers Medicaid

"Intermediary" and "Carrier"

a. Medicare "**intermediaries**" are insurance companies who process claims under contract to the federal government for Part A "providers" which include hospitals, skilled nursing facilities, home health agencies and hospice.

b. Medicare "**carriers**" are insurance companies under contract to the federal government who process claims for Part-B services, including physician services.

MEDICARE ELIGIBILITY

Medicare is an entitlement program. This means if you meet the criteria, you are **entitled** to Medicare benefits. The following requirements are called "eligibility criteria."

BASIC REQUIREMENTS FOR MEDICARE ELIGIBILITY:

Age 65 and Older: With some exceptions, you must be 65 years of age or older to be eligible for Medicare benefits, **and** must qualify under one of the following conditions:

1. receive Social Security benefits
2. receive Railroad Retirement Act benefits
3. be a spouses, ex-spouse, widow or widower (age 65 and over) of a person who qualifies for Medicare benefits.
4. be a transitional eligible (a person who turned 65 shortly after Medicare was established.)
5. **Exceptions to the age requirement:**
 - **Social Security disability:** Individuals of any age who are entitled to Social Security or Railroad Retirement Disability benefits for 24 months or more are eligible for Medicare coverage in the 25th month.
 - **End stage renal disease (ESRD):** Persons of any age with permanent kidney failure, needing regular dialysis, or have had a kidney transplant and are entitled to or receiving Social Security benefits, may be eligible for Medicare coverage. Maintenance dialysis patients are eligible after a three-month waiting period. Kidney transplant patients and those who participate in a self-care training program are eligible immediately.

PEOPLE WHO ARE INELIGIBLE FOR MEDICARE

- 1. The Younger Spouse of a 65-Year Old Who Retires:** If one spouse becomes eligible for Medicare, retires, and no longer has group medical insurance, their younger spouse is not eligible for Medicare. [Solution: She may get coverage through the same group plan via the COBRA Continuation of Group Health Coverage election (see page 59-60 of this chapter for COBRA summary); she may have group insurance offered through her own employer; or she may purchase a non-group major medical coverage via an insurance company or Health Maintenance Organization.]
- 2. If a person retires before age 65 and begins receiving Social Security pension checks,** they do not qualify for regular Medicare yet because they are not yet 65 or older. [Solution: they may elect to continue coverage with their employer's plan via the COBRA Continuation of Group Coverage election; or, their spouse may be covered by a plan for actively employer persons.]
- 3. Citizenship and Social Security limitations**

Some people may not qualify for Medicare because they:

- Do not have 40 quarters of Social Security contributions. [Solution: work and acquire sufficient credits with Social Security.]
- Are not yet United States citizens or aliens who have been lawfully admitted for permanent residence for **FIVE YEARS**. [Solution: try to purchase a non-group major medical plan or HMO coverage; seek employment with group health insurance benefits; use free hospital care pool and neighborhood health centers with sliding fees; other options may exist.]
- Or, are not residents of the United States.
- Or, they do not yet have a Social Security number [solution: call SSA at 1-800-772-1213 to apply for a Social Security number.]

ENROLLING IN MEDICARE

Enrollment is the process by which an eligible Medicare beneficiary applies for Medicare coverage under Part A and/or Part B. There are **three types of enrollment**: automatic, voluntary and standard enrollment procedures.

1. AUTOMATIC ENROLLMENT

Enrollment in Part A is “automatic” only for those persons who have previously filed for monthly pension benefits before the age of 65 (e.g. at age 62) under Social Security or the Railroad Retirement Act. For non-disabled Social Security pensioners, Medicare coverage will not be activated until he or she turns age 65.

These persons receive in the mail an "Automatic Enrollment " notice and Medicare card from Social Security notifying them of Part A enrollment and informing them that they will be enrolled in Part B unless they refuse Part B.

All persons who are eligible for Medicare premium-free do not pay a premium for Part A benefits, but they do pay a monthly premium for Part B benefits, which is deducted from their monthly Social Security checks.

(1). If the beneficiary **does not want** Part B, he/she must sign a card stating they want to reject Part B and send the card back to Social Security. If the person wants to keep Part B, then they do not have to return the card. As you can imagine, this system has caused some confusion and has created errors in that some cards are never received.

(2). A person who shall be enrolled into Medicare automatically should receive this card at least 30 days prior to his/her 65th birthday or 24th month as a disabled Medicare beneficiary; if a problem occurs, then they should contact the Social Security Office.

PURCHASING MEDICARE : THE VOLUNTARY ENROLLMENT PROCEDURE

Most people *do not* pay a premium for Part A because they or their spouse paid into the Social Security trust fund. But some people 65 or older do not meet the requirements for premium-free Hospital Insurance (Part A). **People in this category can purchase Part A by paying a monthly premium.** This is called "premium hospital insurance." In 1997, if you have less than 29 quarters of Social Security coverage, your Part A premium will be \$311 a month. If you have 30 to 39 quarters of Social Security coverage, your part A premium will be \$187 per month. Premium amounts change each January.

1. A person 65 or older who is not eligible for Social Security of Railroad Retirement benefits may purchase Medicare coverage if they are an American citizen or an alien lawfully admitted for permanent residence who has resided in this country for five consecutive years before applying for Medicare.
2. Although a person can voluntarily enroll in Part B without enrolling in Part A, all Part A enrollees are required to enroll in Part B too.
3. If a person cannot afford to voluntarily enroll in both Medicare A and B, he/she should be encouraged to enroll in Part B at least.
4. Persons who purchase Medicare coverage are named "voluntary enrollees".

STANDARD ENROLLMENT PROCEDURE AND ENROLLMENT PERIODS

A popular myth about Medicare is that Medicare will know when you turn 65. This is false. Remember that Medicare and Social Security are two entirely separate entitlement programs. Many persons file to receive their pension many years before they retire from work and leave their employer health plan. Only these retirees can expect Medicare to "know" that their 65th birthday is approaching.

All other persons must notify Medicare of their intent to receive retirement pension benefits and/or Medicare as of, or after, the age of 65. Once they become **age eligible (65), [or await the 24 month waiting period for disabled Medicare beneficiaries], they may enroll into Medicare Parts A and/or B..**

ENROLLMENT PERIODS for Medicare's Part B:

There are three periods of time in which a beneficiary may enroll in Medicare Part B. They are the special, initial, and general enrollment periods. It is very important to understand when someone can enroll into Medicare Part B because there is a very steep penalty for anyone who delays Part B enrollment while they were not covered by an employer based health plan.

PENALTIES FOR DELAYED ENROLLMENT

In Medicare Part B the penalty for delayed enrollment is 10% for each year that he/she was late enrolling in Medicare. This surcharge increases each year as the Medicare premiums increase! The late enrollee must pay this surcharge every month for the rest of their lives.

SPECIAL ENROLLMENT PERIOD

The special enrollment period is for people aged 65 and older who are employed and/or will be continuously covered by an employer's health plan (their own employer or their spouse) after their 65th birthday.

The special enrollment period takes place during the 8 month period beginning with the month you are no longer covered under the employer's plan, or you are no longer working, **whichever comes first**.

Effective May 1, 1986, employers with twenty or more employees are required to offer active employees over age 65 and their spouses the option of receiving the exact same health insurance package they offer to their younger employees. For aged employees, the employer's insurance is the primary payer on all health insurance claims while Medicare is the secondary payer. This is referred to as the "Working Aged Law".

If a Medicare beneficiary who works for an employer with twenty or more employees wishes to have Medicare as the primary payer, he or she must decline coverage under the Employer Health Plan. The company may offer limited plans for services which are non-Medicare services, such as prescription eyewear or dentistry, but it cannot frame a health plan which echoes the characteristics of a Medicare Supplement plan.

Many clients may not know that EMPLOYER INSURANCE IS NOT SECONDARY TO MEDICARE FOR THE WORKING AGED or one's aged spouse, unless the employer has fewer than 20 employees.

The special enrollment period lasts 8 months and begins when the employer's coverage ceases to be primary which is usually when a person or his/her spouse retires or loses health care coverage for active employees. One can enroll into Medicare's Part B without paying the Part B penalty (the surcharge on premium of 10% for each year someone delayed enrolling into Part B and lacked employer based group health coverage).

Special Enrollment Month of Termination Enroll during month, or immed. after coverage ends, A & B start with no gap.	Mo. 2	Mo. 3	Mo. 4	M	Mo. 6	Mo. 7
	_____	_____	_____	_____	_____	_____

Proceed carefully and fully compare the benefits and costs between the employer insurance coverage and Medicare coverage supplemented by a medigap plan or an HMO senior plan. A SHINE counselor can be very helpful in discussing the merits of each insurance coverage option, employer versus Medicare with a supplement, whenever a client is thinking about dropping their employer health coverage. For example, even though someone must be offered the same plan as all other employees, the employee's cost-sharing premium payment may be higher for the employer group plan than if they disenrolled from the company plan, enrolled into Medicare and purchased a medigap or HMO plan.

INITIAL ENROLLMENT PERIOD

The initial enrollment period is a seven month period, encompassing three months preceding an enrollee's 65 birthday; the actual month of the 65th birthday; and the three months following enrollee's 65th birthday.

An individual may sign up for Medicare no sooner than three months prior to the month of his/her 65th birthday, the month of his/her 65th birthday and no later than three months after the month of his/her 65th birthday. The date of enrollment determines the effective date of Medicare coverage.

- Enroll during the three months prior to month of 65th birthday, and coverage starts 1st day of birthday month;

- Enroll during the month of the 65th birthday, and coverage starts 1st day of following month;
- Enroll during the three months after the 65th birthday month, and coverage starts a month to two months later.

INITIAL ENROLLMENT PERIOD 7 Months – 3 Month Period Before, Birth Month, AND 3 Months After Birth Month						
Mo. 1	Mo. 2	Mo. 3	Birth Month	Mo. 5	Mo. 6	Mo. 7
_____	_____	_____	_____	_____	_____	_____

GENERAL ENROLLMENT PERIOD

The general enrollment period is for late enrollees. Late enrollees are persons who rejected Part B insurance during their initial enrollment period and did not have health coverage through an employer health plan for actively working employees. Or, late enrollees are voluntary enrollees who did not apply during their initial enrollment period near their 65th birthday. Late enrollees can apply for Part B of Medicare **ONLY during** the general enrollment period.

This general enrollment period is from January 1 to March 31 of each year and **coverage will not take effect until July 1 of that year.**

The penalties for late enrollment are a permanent surcharge of 10% of the premium for each 12 month period of late enrollment, and a waiting period before Medicare Part B coverage becomes effective. Be alert! The beneficiary must pay this surcharge for the rest of their lives. Make sure your client's understand when they need to enroll into Medicare P to avoid the surcharge.

General Enrollment Period for Medicare Part B

Enroll during January-March and Part B shall become effective as of July 1st that year.

Jan	Feb	Mar	Apr	May	June	July 1st Effective Date	Aug	Sept
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MEDICARE CARD

The Medicare card shows what parts of Medicare the beneficiary has as well as his/her name and claim number.

- * The information listed on the card is what is listed in the Social Security Administration computer system and is "accurate" unless corrected via a Social Security Office inquiry. Therefore, any misspelled names are to be used as printed on the card for claims and inquiries. At the time of correction, a person should ask that a new card be issued.

- * Each Medicare claim number is unique to that beneficiary. The Medicare card or claim number cannot be used by a spouse or anyone other than the beneficiary named on the card.

- * The claim number has nine digits and a letter. The suffix of this number indicates how the beneficiary qualifies for Medicare. Most claim numbers are the beneficiary's own Social Security Number; however, some spouses or widows and widowers are eligible for Medicare based upon their spouse's record of paid employment. These individuals will have a Medicare claim number that is based upon the other spouse's social security number. Lastly, Railroad beneficiaries have the letter (prefix) before the claim number.

- * Beneath the words **"IS ENTITLED TO"** are the words:

"HOSPITAL INSURANCE" (PART A) or

"MEDICAL INSURANCE" (PART B) or both,

and to the right of that, the date each type of coverage began.

- * The effective dates of coverage may not be the same for both parts.

For example: The beneficiary who continued working after age 65 and was covered by an employer-related group medical plan may have enrolled in Part A (Hospital) coverage as soon as they turned 65 but may have delayed enrollment in Part B (Medical Insurance). One can postpone enrolling into Medicare Part B without penalty until the plan for actively working employees is canceled. Many people delay enrollment into Part B so they can take advantage of a federally mandated 6-month open enrollment period for Medicare supplemental insurance that begins on the effective date of their Medicare Part B (Medical Insurance) coverage.

* If a person loses his/her card or has questions regarding Medicare coverage they should contact a local Social Security office, or call the central Social Security office at 1-800-772-1213.

*** ALWAYS FIND OUT WHETHER A PERSON IS ENROLLED IN PART A OR PART B OR BOTH, SINCE COVERAGE IS VERY DIFFERENT IN EACH PART.**

MEDICARE COSTS AND PROGRAMS THAT HELP

Note: See the Public Benefits Chapter for additional details about public benefits and financial assistance.

Medicare was never intended to provide all medical services free of cost to the people who receive the benefits. At the front of this chapter is a page, updated annually, with the deductibles, co-payments, and premiums Medicare beneficiaries pay as partial participation in the cost of their care.

Medicare Part A (Hospital) benefits are premium-free to fully insured Social Security participants after age 65. **Medicare Part B (Medical)** participants must pay a monthly premium, which is deducted from their Social Security retirement benefit check if they have applied for retirement benefits. **Those not eligible** for premium-free Medicare Part A (Hospital) coverage and who purchase Medicare coverage may pay premiums for Parts A and B or for Medicare Part B if they buy only Part B coverage.

Two “Medicare Buy In Programs” administered by the Department of Medical Assistance (Medicaid) can help low-income seniors pay for Medicare premiums, deductibles and co-payments.

QUALIFIED MEDICARE BENEFICIARY (QMB) PROGRAM

Federal law provides that low-income Medicare beneficiaries should not be denied needed medical care because of the cost of deductibles, co-payments, or Medicare Part A and B premiums.

Under the **QMB** program, a person is eligible to have their deductibles, co-payments, and Medicare premiums paid for them if they meet the following:

- Income at 100% or less of the Federal Poverty Level;
- Do not have assets of more than \$4,000 for a single person, \$6,000 for a couple;
- Be eligible for Medicare

Persons who wish to apply for QMB benefits should contact the MassHealth Enrollment Centers, the state offices responsible for administering the QMB program.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMB)

SLMB is a new program for certain low-income Medicare beneficiaries that began January 1, 1993. It is for those whose income is below 120% of the national poverty guidelines, and assets less than \$4,000 for a single person, \$6,000 for husband and wife.

For those who qualify, Medicaid will pay their Medicare Part B premium. Applications for this program are processed through Medicaid's MassHealth Enrollment Centers.

MEDICARE PART A HOSPITAL INSURANCE

- TOPICS**
- **GENERAL INTRODUCTION**
 - **HOSPITAL COVERAGE**
 - **SKILLED NURSING FACILITY CARE**
 - **HOME HEALTH CARE**
 - **HOSPICE CARE**
 - **PROSPECTIVE PAYMENT SYSTEM**

MEDICARE HOSPITAL INSURANCE

Medicare (Part A) helps pay for services you receive in:

- * a hospital,
- * skilled nursing facility,
- * home health agency
- * hospice program

Medicare's Part A is premium-free for those who have paid sufficient Medicare taxes under the Federal Insurance Contribution Act (FICA). For American citizens and lawfully admitted aliens who are not eligible for premium-free Part A, the Part A premium for 1995 is \$289/month.

HOSPITAL COVERAGE

Hospital inpatient care is covered if a physician prescribes the treatment, the beneficiary requires care that can only be received in a hospital, and Medicare approves the stay.

Four conditions must be met to determine if the hospital stay is **medically necessary** before Medicare will pay for inpatient hospital care.

1. A doctor prescribes inpatient hospital care for treatment of illness or injury
2. The care required can only be provided in a hospital
3. The hospital is participating in Medicare
4. The utilization review committee does not disapprove the hospital stay.

Covered Days Under Medicare Part A

- a. The Medicare beneficiary is responsible for the \$736 Part A deductible per **benefit period**.

BENEFIT PERIOD a period of time which Medicare pays for your care in a hospital or skilled nursing facility. For a hospital, the benefit period begins the first day you receive inpatient care and ends when you have been out of the hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge). There is no limit to the number of benefit periods you can have for hospital and skilled nursing facility care.

(1) Medicare basically pays 100% of hospitalization for up to 60 days with the exception of the Part A deductible.

(2) The Part A deductible and co-insurance increases January 1st of each year. HCFA establishes the amount of the new Part A deductible by federal regulation.

(3) Each Medicare benefit period provides 90 days of hospital care, if needed.

(a) If a Medicare beneficiary is out of the hospital and has not received skilled care in any other facility for 60 or more consecutive days, a new benefit period begins with the next hospital admission. There is no limit to the number of benefit periods a Medicare patient can have in their life-time, but remember: the Part A deductible will apply to each benefit period.

(b) The benefit period is not based on any calendar year.

For days 61-90 in a benefit period, Medicare pays all hospital costs except for \$184.00 per day co-insurance (in 1995).

(1) The beneficiary pays the co-insurance per day for the benefit period of the 61st-90th day.

(2) Medicare pays the balance of hospital expenses per day from the 61st to the 90th day.

(3) The 1st - 60th and the 61st - 90th benefit periods are renewable.

c. In addition to the renewable benefit period, each Medicare beneficiary has 60 "lifetime reserve days".

(1) These days are not renewable.

Before lifetime reserve days can be used, the Medicare recipient must have exhausted their 90 inpatient hospital days in a benefit period and remain hospitalized.

(b) The lifetime reserve days may be used in a single hospitalization or in several spells of illness over the life of the recipient.

(c) Very few people ever exhaust their 60 lifetime reserve days.

(2) The beneficiary pays the \$368 per day co-insurance for each lifetime reserve day.

(3) Medicare pays the balance of hospital expenses for each reserve day.

(4) Medicare pays nothing beyond 150 days of Medicare covered hospitalization. These days must be used in one spell of illness.

(5) The law requires participating hospitals to accept Medicare payment as payment in full for the covered services. Those hospitals are prohibited from billing the Medicare patient for anything other than the deductible and copayment amounts, plus any amounts due for non-covered items of service.

Services Covered During Hospital Stay:

a. Semiprivate room and board,

- b. Special care units such as intensive care unit or coronary care unit,
- c. General nursing services,
- d. Drugs administered to you while you are in the hospital,
- e. Lab tests included in the hospital bill,
- f. Radiology services included in the hospital bill, i.e., x-rays, radiation therapy,
- g. Medical supplies such as casts, splints and surgical dressings,
- h. Operating and recovery room costs,
- i. Rehabilitation services such as physical therapy, occupational therapy, and speech pathology services,
- j. Use of appliances (i.e., wheelchairs),
- k. Blood transfusions after the first three pints.

Services Not Covered under Medicare Part A During Hospital Stay:

- a. Physician services
- b. Personal convenience items (i.e., television, telephone),
- c. Extra charges for private room unless it is medically necessary or the only type of room available,
- d. The first three pints of blood (unless the blood deductible has been satisfied under part B),
- e. Private duty nursing.

Miscellaneous Hospital Coverage

a. Care in psychiatric hospital

(1) Medicare pays for no more than 190 days of inpatient care in a participating psychiatric hospital in a lifetime.

(2) The hospital deductible applies to psychiatric hospital admissions as well as to acute care hospital admissions.

b. Care in foreign hospital

Medicare usually does not pay for care outside the United States.

(1) Medicare may pay for care in a qualified Mexican or Canadian hospitals in three situations.

(a) The beneficiary is in the United States when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest United States hospital that can provide emergency services.

(b) The beneficiary lives in the United States and the Canadian or Mexican hospital is closer to their home than the nearest United States hospital regardless of emergency cases.

(c) The beneficiary is in Canada traveling by the most direct route to or from Alaska and another state and an emergency occurs that requires that you be admitted to a Canadian hospital. (Emergencies that occur while one is vacationing in Canada are not covered.)

(d) Claims for these services usually requires special handling.

If a Medicare beneficiary plans to travel outside the United States, he/she should investigate these insurance matters:

- (a) Check current Medicare supplement insurance to see if it has worldwide coverage.
- (b) Buy a specialty policy that will cover them for accidents and illnesses outside the United States.
- (c) Contact a travel agency for a short term health insurance policy for foreign travel.

Care in a Christian Science Sanitarium

(1) Medicare pays for inpatient care received in a participating Christian Science sanitarium if it is operated or listed by the First Church of Christ, Scientist, in Boston.

(2) Check to determine if your state has a Christian Science sanitarium.

SKILLED NURSING CARE

Medicare Hospital Insurance helps pay for inpatient skilled nursing care in a Medicare participating skilled nursing (SNF) or rehabilitative services facility following a hospital stay if a person's condition requires daily skilled nursing or rehabilitation services. This service by Medicare is very limited and restrictive. Less than 2% of nursing home payment is paid by Medicare.

A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide **skilled nursing care, rehabilitation services, and other related health services**. Not all nursing homes are skilled nursing facilities and many in the United States are **not** certified by Medicare.

1. Medicare requires that certain conditions be met before payment is made for services.

- a. The provider must be a Medicare participating skilled nursing facility (SNF). Some facilities do not participate in Medicare, or have only some designated beds that participate.
- b. The bed the patient occupies must be a Medicare participating bed (in a Medicare-participating SNF).
- c. The patient's physician must certify that the patient needs and receives daily skilled care.
- d. The individual must have had a minimum prior 3-day stay in the hospital.
- e. The individual must have been admitted to an SNF within a specified time period (generally 30 days) of discharge from the hospital.
- f. The individual must need and receive a covered SNF level of care (see para. 5). Not all "skilled" services are considered skilled for Medicare reimbursement.

Covered Days For Medicare SNF Care

a. Medicare Hospital Insurance will pay up to 100 days per benefit period.

(1) Days 1-20, Medicare pays 100%.

(2) Days 21-100, Medicare pays all but a daily coinsurance amount (\$95.00 per day in 1997).

(3) Medicare Part A provides no coverage beyond **100 days per benefit period** in a SNF.

b. The 100 day benefit period may be renewed by remaining out of the SNF 60 consecutive days, returning to the hospital for at least 3 days, being admitted to a SNF within 30 days of hospital discharge and meeting all of Medicare's skilled care criteria.

Major Services Covered In A Skilled Nursing Facility:

- a. Semiprivate room
- b. All meals (including special diets)
- c. Regular nursing services
- d. Rehabilitation services (physical, occupational, and speech therapy)
- e. Drugs and medications furnished by the SNF during the stay
- f. Use of medical equipment and supplies furnished by the SNF

Services Not Covered in a Skilled Nursing Facility:

- a. Personal convenience items, i.e., television

- b. Extra charges for a private room unless it is medically necessary

NOTE: Physician services are covered under Medicare Part B

Definitions Of Levels Of Care:

a. Skilled care

(1) Skilled care in a nursing home is care in which the services are ordered by, and included in the plan of treatment established by the physician.

(2) Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist.

(3) Often, a patient will improve and later start to receive less medical attention. Intermediate/custodial care would be more appropriate.

(4) A person does not automatically qualify for Medicare SNF payment just because they receive some skilled services. In order to qualify for Medicare payment in a SNF, a person must need and receive a covered SNF level of care - this means daily skilled services which, as a practical matter, can only be provided in a SNF. Part A will not pay for a patient who needs skilled care only occasionally, such as once or twice a week, or for someone who does not need to be in a SNF to get skilled services.

b. Intermediate Nursing Care

(1) Intermediate care in a nursing home requires less medical attention than regular skilled care. This level is distinguished by 8 hours of licensed nursing care.

(2) Medicare does not pay for intermediate care.

c. Custodial Care

(1) Custodial care is primarily for the purpose of meeting personal needs and could be provided by persons who do not have professional skills.

(2) A patient usually receives this level of care because he/she is unable to take care of him/herself and is not in the nursing home for medical reasons.

(3) Custodial care is provided to meet the personal needs such as: bathing, dressing, toileting, transferring and eating.

(4) Medicare does not pay if a person requires only custodial care.

MEDICARE'S HOME HEALTH BENEFIT

Requirements For Medicare Home Health Coverage:

- a. The home health care agency must be a Medicare-participating agency.
- b. The patient must be under a doctor's care and the doctor must authorize the medical treatment furnished by the home health care agency. Reports concerning the patient's condition are forwarded to the doctor by the home health care agency.

c. The patient must be “HOMEBOUND”; this means that it is a “considerable and taxing” effort to leave home; it may also mean that one needs the assistance of another person to leave home. A person may be homebound even though they are physically able to attend a religious ceremony, for example, with the assistance of someone else and/or the use of ambulatory aids such as walkers and wheelchairs.

d. The patient must meet either intermittent (at least once every 60 days) or part-time (less than full-time) skilled nursing care, physical therapy, occupational therapy or speech therapy.

e. To find out if a beneficiary qualifies for coverage under the Medicare home health benefit, the beneficiary should ask his physician to refer him to a Medicare-certified home health agency in the area. In the alternative, a beneficiary can contact a home health agency directly and ask for their assistance in setting up the services they need. The home health agency will evaluate his care and advise him whether, in their opinion, he meets the requirements for Medicare coverage. Home health agencies do not charge for this evaluation . A home health agency is a public or private agency that specializes in giving skilled nursing services, such as physical therapy, in the home.

1. Medicare pays 100% for all covered and medically necessary home health services under either Part A or Part B as long as the beneficiary continues to meet the coverage requirements. Home health care agencies work closely with Medicare because a high percentage of the agencies' business is with Medicare beneficiaries. A Medicare certified home health agency always takes Medicare assignment.

2. Home health visits are not subject to the \$100 calendar year deductible.
 - a. Payment is made directly to the Part B participating agency.
 - b. Medicare will pay for home health visits for an unlimited number of visits during an unlimited period of time as long as it is medically necessary and the coverage requirements are still met.
3. The intent of home health visits is to deliver skilled medical attention to home-bound patients.
4. Services Medicare Pays for During Home Health Visits.
 - a. Part-time or intermittent skilled nursing care,
 - b. Therapy (physical, speech, and occupational),
 - c. Medical social services (i.e., dietary counseling),
 - d. Part-time or intermittent care (e.g. bathing and changing of dressings).
 - e. Medical supplies, and
 - f. Durable medical equipment (subject to 20% coinsurance).
5. Medicare Payment for Home Health Visits Does Not Cover:
 - a. Drugs,
 - b. Homemaker services,
 - c. "Meals on Wheels" or personal services.

[intentionally left open]

MEDICARE'S HOSPICE CARE

Hospice is a public agency or private organization whose primary role is to provide pain relief and symptom management to terminally ill patients.

1. Medicare's requirements for payment of hospice care:

- a. Doctor certifies the patient is terminally ill (diagnosed as having six months or less to live if the illness runs its normal course).
- b. Patient has elected to receive care from Hospice instead of regular Medicare benefits for the terminal illness. By electing Hospice, a patient is agreeing to forego all further medical treatment except for pain management. However, it is possible under certain conditions to return to regular Medicare and receive treatment.
- c. Care is provided by Medicare certified hospice program.

2. Medicare will pay 100% for most covered services.

- a. Medicare will pay for up to two 90-day periods, one 30-day period, and a fourth unlimited extension period.
- b. The beneficiary will have to pay small co-insurance fees for outpatient drugs and inpatient respite care.

3. Services Covered When Provided By Hospice:

- a. Doctor and nursing services
- b. Home health aid and homemaker services
- c. Medical supplies and appliances

- d. Physical, occupational and speech therapy
 - e. Drugs (including outpatient drugs that are for the purpose of pain relief)
 - f. Counseling
 - g. Medical social services
 - h. Short term inpatient care (including respite care)
4. The Medicare hospice benefit does not pay for treatment other than for pain relief and symptom management of a terminal illness.

BLOOD

1. After the first three pints or units, Medicare Hospital Insurance Part A pays for all costs for blood (whole blood or units of packed red cells), blood components, and the cost of administration for a Medicare inpatient of a hospital or skilled nursing facility. The Medicare patient is responsible for the first three pints or units by either paying the administrative fees or having the blood replaced, or both.

2. If the blood is replaced by the Medicare beneficiary or another person on his behalf, the hospital or skilled nursing facility cannot charge for the blood, only the administrative charges. (The replacement cost for blood is approximately \$60 per unit.) However, there may be associated costs with the actual drawing of the donated blood.

THE PROSPECTIVE PAYMENT SYSTEM (PPS)

1. The Medicare PPS pays hospitals fixed dollar amounts that are determined per case according to an individual's diagnosis for each hospital stay.

a. The system categorizes illness/inpatient admissions into nearly 500 diagnosis related groups (DRG).

b In cases of extra long stays or very high costs, known as "outliers," extra payment can be made to the hospital.

2. PPS does not change the beneficiary's hospital cost.

a. Hospitals may not bill the beneficiary over the amount of the Medicare hospital deductible and applicable coinsurance.

3. A beneficiary has the right to appeal a hospital's decision end the hospital stay before (to terminate Medicare coverage) for the inpatient beneficiary.

a. The hospital should issue a written notice of non-coverage to the beneficiary. It should not say he/she must leave the hospital; instead, it should clearly state that if the beneficiary chooses to stay in the hospital, he/she will be responsible for services provided beginning on the third day after he/she receives the notice.

b. The notice should also explain the appeals procedure.

c. The beneficiary can appeal the discharge by calling the PRO (Peer Review Organization) before noon of the next business day following the written Notice of Non-Coverage.

- d. The PRO must review the beneficiary's records by the end of the following business day.
- e. If the PRO decides that hospital care is still needed, it is the beneficiary's right to remain in the hospital at no extra charge.
- f. If the PRO decides that the beneficiary no longer requires Medicare covered hospital care, he/she may stay in the hospital at no charge until noon of the day after receiving the decision.
- g. The beneficiary is not responsible for the services provided during the initial appeal process whether the PRO agrees or disagrees with the hospital. If the beneficiary disagrees with the PRO decision, he/she may appeal again within 60 days.
- h. If the beneficiary disagrees with the PRO decision, he/she may appeal that decision within 60 days.
- i. In Massachusetts, the Peer Review Organization is located at 300 Bear Hill Road. Waltham, MA 02154, and the telephone number is (617) 890-0011.
- j. PRO's are groups of physicians and professionals in each state who are paid by the federal government to help Medicare decide when hospital care is necessary and meets accepted Medicare standards.

{See Chapter 2 "Medicare Appeals and Claims Processing for more details on the Medicare beneficiary's rights to appeal medical decisions rendered by various medical providers.}

UTILIZATION AND REVIEW

1. Utilization and Review committees (URC) continually review clients' stays in hospitals and skilled nursing facilities. These committees work within facilities and are comprised of doctors or professionals not related to the patients involved. Each admitted person's doctor must satisfy the URC that the patient continues to need an acute hospital level of care.
2. The URC determines if the patient is meeting Medicare's standards for needing medical care in a hospital setting; sometimes, the URC will overrule the patient's doctor and determine it is time to be discharged from the hospital (to home or another level of care).
3. The URC committee has the authority to terminate Medicare's obligation to pay for medical services in a hospital or skilled nursing facility.
4. All Medicare participating hospitals and skilled nursing facilities have a U&R committee. This committee is not related to the PRO which was discussed previously.

LIMITATION OF LIABILITY

1. In some instances, a beneficiary who **did not know** and **did not have reason** to know that services would not be covered is protected from liability to pay for those services. These 3 specific types of situations are:
 - a. When the services were not found to be “reasonable and necessary”;
 - b. When care was found to be “custodial”; or

- c. When home health services are not covered because the beneficiary was not “homebound” or did not require intermittent or part-time skilled nursing care.

In order for the beneficiary to have know that the services would be denied for these reasons, he/she must have been given advance notice by the provider. The beneficiary must receive and explanation of why the provider predicts Medicare denial, so the beneficiary can make an informed decision about whether to request the service and pay for it. Providers have developed practices to give written notices whenever they anticipate Medicare coverage will cease. Beneficiaries can always ask for a provider’s decision to be reviewed. The provider can submit a “demand billing” to Medicare to get a formal determination. Also, a beneficiary can call the Medicare carrier (in Massachusetts, Medicare carrier is 1-800-882-1228) and learn more about what kinds of medical services are, and are not, covered by Medicare. The Medicare Handbook provides information as well about what types of services are covered.

MEDICARE PART B

MEDICAL INSURANCE

TOPICS:

- . GENERAL INTRODUCTION
- . PART B BENEFICIARY COSTS
- . THE PART B PAYMENTS
- . PHYSICIAN PAYMENT REFORM
- . PART B BENEFITS
- . MEDICARE AS SECONDARY PAYER
- . MEDICARE EXCLUSIONS

Medicare Medical Insurance Part B

Medicare Medical Insurance covers physicians' services, outpatient hospital care, ambulance services, prosthetic devices, medical equipment, and a number of other health services and supplies not covered in Medicare's Hospital Insurance.

The Part B beneficiary costs include monthly premiums, an annual deductible, co-insurance, and excess charges.

1. The monthly premium in 1997 is \$43.80.
 - a. The Part B premium is normally deducted from the Social Security check.

b. For persons who are enrolled in Part B but do not receive a Social Security check, bills are issued for premiums every three months.

c. For American citizens and lawfully admitted aliens who are not covered by Social Security and are not eligible for premium-free Part A of Medicare, the premium is the same as for those who are eligible (\$43.80/month).

2. The \$100 Deductible

a. A beneficiary is responsible for the first \$100 of **Part B approved charges** in each calendar year. The calendar year, January 1 - December 31, is the Part B benefit period and is automatically renewable.

b. Services not covered, and charges in excess of the Medicare approved charges, do not apply to the deductible.

3. Co-insurance

a. Medicare Part B pays 80 percent of charges which it approves for coverage.

b. A beneficiary is responsible for 20 percent of the Part B approved charges for covered services (after the deductible).

c. A beneficiary must also pay the difference in charges between the actual charge and the Medicare approved charge when the physician or supplier does not accept Part B assignment. This is called excess charges.

Medicare Part B Payment System

Methods of payment

a. Assignment means that a physician or supplier agrees to accept Medicare approved charges as "payment in full."

(1) "Participating providers" must accept assignment in all cases. A "non-participating physician" may accept assignment on a case-by-case basis.

(2) Physicians and suppliers must elect to participate or not participate each year. This is subject to change at HCFA's discretion, and, again it does not prohibit any provider from accepting assignment anyway.

(3) When physicians or suppliers accept assignment, Part B pays 80 percent of the allowable charge, and the beneficiary is responsible only for paying the 20 percent co-insurance amount of the Medicare approved charge.

(4) The simplest way to find out if a provider accepts assignment is to ask him/her.

(5) A listing of all participating providers is furnished free by the Medicare carrier. It is called the MEDPARD and is usually available in late spring each year. Remember, however, that other non-participating providers can take assignment and will not be listed in this book.

b. The non-assigned claim means that a physician or supplier does not agree to accept Medicare's approved charge as payment in full.

(1) The beneficiary is responsible for the 15% excess charge (in addition to the 20 percent co-insurance).

(2) Non-participating physicians usually have non - assigned claims.

(3) If “elective” (meaning surgery that can be scheduled in advance) surgery is to cost over \$500, non- participating physicians who do not accept assignment must do the following:

(a) Advise patient of Medicare allowed charges and the excess costs the physician is charging for the service, or

(b) Make refund to the beneficiary if no disclosure is made.

(c) Medicare defines elective surgery as surgery that can be scheduled in advance and is not an emergency, and if delayed would not result in death or permanent impairment of health. Medicare makes this decision on a case by case basis.

PHYSICIAN PAYMENT REFORM

Congress has adopted a new system, "Physician Payment Reform," designed to control rising Medicare expenses for Part B.

1. After 1991, the Medicare Part B payment has been based on new formulas as mandated by Physician Payment Reform. These changes are said to be the most extensive since Medicare's inception in 1965. The approved charge allowed by Medicare eventually will be based on a fee schedule. The overall fee schedule is designed to contain costs and to equalize reimbursements.

- a. The fee is a fixed amount calculated on the basis of the relative value of a service and adjusted slightly for the overhead costs of running an office and the geographical location. The relative value formula measures the time and resources a doctor devotes to each procedure.
- b. The fee which is allowed by Medicare for a particular service will be similar for all doctors performing the service with only slight adjustments for the doctor's specialty or geographical location.
- c. One intention of Physician Payment Reform is to increase reimbursement for primary services and to decrease Medicare payments for specialty services.
- d. Physicians who bill for non-assigned claims are limited by percentage to set maximum charges above the new approved amount. For 1992 these limits were calculated by Medicare based on 120% of the lesser of the prevailing fee, the approved amount or the physician's actual charge. In other words, a physician could not charge an amount above 120% of the figure which Medicare set for him/her using its formula. In the past, beneficiaries were not always able to determine what the set limiting charge was to be, although in 1992 often it was 120% of the approved dollar amount shown on the EOMB: Explanation of Medicare Benefits.
- e. As of September 1991, all physicians and suppliers are required to submit all claims for Medicare patients.
- f. This system should decrease beneficiaries out-of-pocket expenses under Part B.

g. In 1993 the matter is simpler. The limiting charge for non-assigned claims is based on a flat 115% of the approved rate and the beneficiary should be able to determine if that limiting charge has been exceeded by calculating from the amount on the EOMB. Remember, this only applies to non-assigned claims.

Part B Benefits

1. Coverage for Physician Services

a. Part B helps pay for covered services received from a doctor in his/her office, hospital, SNF, home of patient, or any other location in the United States. The term doctor includes:

- (1) Doctors of medicine (M.D.) or osteopathy (D.O.)
- (2) Doctors of dental surgery or dental medicine*
- (3) Chiropractors*
- (4) Optometrists*
- (5) Podiatrists*

* Part B services by these physicians are limited.

b. Major Doctors' Services Covered:

- (1) Medical and surgical services including anesthesia,

- (2) Diagnostic tests and procedures that are part of the patients treatment,
- (3) Radiology and pathology services (in or out of the hospital),
- (4) Drugs that cannot be self-administered,
- (5) Transfusions of blood and blood components (beginning with 4th pint),
- (6) Visit to physician for second opinion about recommended surgery.

c. Doctors' Services Which May Be Partially Covered.

(1) Chiropractors' Services:

- (a) Part B pays for manual manipulation of the spine to correct a subluxation that is demonstrated by x-ray to exist.
- (b) Medicare will not pay for x-rays furnished by a chiropractor.

(2) Podiatrists' Services:

- (a) Medicare will help pay for covered services provided by a podiatrist. Examples of those include hammer toe deformities and heel spurs and treatment of mycotic toenails.
- (b) Medicare will not pay for routine foot care or the removal of corns, calluses and most warts except in some cases when a patient is under the active care of a medical doctor for certain medical conditions. It may pay for routine foot care for a diabetic.

(3) Optometrists' Services

(a) Medicare will pay for an optometrist's services that are involved in the treatment and diagnosis of eye disease; however, this does not include surgery.

(b) Medicare will also help pay for certain lenses used for the treatment of cataracts and follow-up care done after cataract surgery.

(c) Optometrists may also bill for completed eye exams, office visits and diagnostic procedures.

(4) Dentist's services that are covered must involve surgery related to the jaw or setting fractures of the jaw or facial bones.

d. Doctors' Services Not Covered:

(1) Most routine physical examinations and tests related to such examinations (there are limited exceptions)

(2) Most routine foot care,

(3) Examinations for fitting a hearing aids,

(4) Examinations for eyeglasses except those required by cataract surgery,

(5) Most routine dental care or false teeth,

(6) Acupuncture,

(7) Cosmetic surgery unless needed as a result of degenerative disease or damage from an accident (Medicare will not pay for removal of bags under the eyes, a fat chin, or drooping eyelids!),

(8) Experimental medical procedures, and other services that Medicare does not consider medically reasonable or necessary

(9) Services that are rendered by Christian Science practitioners.

2. Coverage Of Outpatient Hospital Services

a. Services Covered:

(1) Services in an emergency room or outpatient clinic

(2) Lab tests and x-rays billed by the hospital

(3) Medical supplies such as splints and casts

(4) Drugs which cannot be self-administered

(5) Blood transfusions furnished to an outpatient beginning with 4th pint

3. Outpatient Treatment For Mental Health Services

a. these services are covered under a special payment rule (62.5 percent of 80 percent or 50 percent of the approved charge). Medicare pays 50 percent of approved charges.

b. Outpatient treatment for mental health can be provided by a physician, a clinical psychologist, or a clinical social worker. In some situations the psychologists and social worker must be under a physician's supervision.

4. Outpatient Rehabilitation Therapy

- a. Doctor must prescribe service (physical, speech or occupational therapy), set plan of treatment and review the plan on a regular basis.
- b. The therapy services can be received in one of three ways:
 - (1) Services can be received in a physician's office.
 - (2) Directly from an independently practicing Medicare certified physical or occupational therapist in his/her office or in the home if such treatment is prescribed by a physician. This is limited to an annual amount of \$900.
 - (3) As an outpatient of a hospital, SNF, home health agency, clinic, rehabilitation agency, or public health agency approved by Medicare.

5. Ambulance Coverage

- a. Part B covers ambulance service in approved vehicles when transportation in another vehicle would endanger the beneficiary's health.
- b. Medicare will pay for transportation from home to the nearest hospital or skilled nursing facility or from the hospital or skilled nursing facility to home.
- c. Medicare will not pay for ambulance use as routine transportation.

6. Durable Medical Equipment and Supplies - Part B covers equipment and supplies under two general conditions:

a. a physician must order or prescribe the equipment prior to purchasing or renting the equipment, **and** the equipment must be medically necessary.

b. Durable medical equipment must be for use in the patients' home and includes:

(1) Oxygen equipment,

(2) Wheelchairs, and

(3) Certain other medically necessary equipment.

c. Covered supplies include:

(1) Prosthetic devices, which are devices needed to substitute for an internal organ (i.e., heart pacemakers), corrective lenses needed after cataract surgery, colostomy and ileostomy bags and certain related ostomy supplies

(2) Artificial limbs and eyes, and arm, leg, back and neck braces

(3) Supplies ordered by a physician in connection with medical treatment immediately after surgery for a specified time (i.e., surgical dressings, splints and casts).

c. Routine first-aid supplies such as adhesive tape and antiseptics are not covered.

7. Home health care services are the same for Part B and Part A. If a person is covered by Parts A and B, then one's home health benefits are received under Part A. The requirements for home health are the same for both Part A and Part B.

8. Other Part B Covered Services:

a. Independent laboratory services

- (1) Part B covers diagnostic tests provided by Medicare certified independent laboratories.
- (2) The lab must accept assignment.
- (3) 100% payment - patient owes nothing.

b. Portable diagnostic x-ray services

- (1) Part B covers these services when received at home if a physician orders them.
- (2) The supplier that provides the equipment must be a Medicare-certified supplier.

c. Mammography screening (effective January 1991):

- (1) Part B covers a mammography screening for women 65 or older at least every other year.
- (2) The screening must be taken on assignment.

- (3) Women in certain age groups or considered at high risk may receive coverage more frequently.
- d. Immunization Shots for the Flu, Pneumonia, Hepatitis B and others.
- e. Pap Smears (effective January 1991):
 - (1) Medicare Part B covers a pap smear to screen for cervical cancer at least every three years. It is considered lab work and covered at 100%
 - (2) Medicare will cover more frequent screening if a physician considers a woman to be at high risk of developing cervical cancer.

MEDICARE AS SECONDARY PAYER

For some services, certain entities must pay first, with Medicare being the secondary payer. Following are specific examples:

- a. Items or services covered by a governmental agency or program (i.e., worker's compensation, VA),
- b. Items or services covered under an employer's group health plan when the employer plan is the primary payer,
- c. Items or services covered under liability or no fault insurance accident plan
- d. See HCFAs booklet entitled Medicare and Other Health Benefits for more detailed information.

SOME MEDICARE JARGON

"reasonable and necessary."

Medicare will only pay for services that are reasonable and necessary for the treatment and diagnosis of an accident or illness. These are services Medicare determines are safe, effective, and medically appropriate.

Only approved charges are considered when calculating the deductible for Medicare Part B (Medical), which means the beneficiary may have more than the dollar amount of the deductible in out-of-pocket expenses before satisfying the deductible. After the Medicare Part B deductible is satisfied, Medicare pays 80% of all approved charges.

Deductibles and co-insurance's. are either fixed dollar amounts or percentage amounts of an actual charge a beneficiary must pay out-of-pocket before or in addition to what Medicare pays. Both parts of Medicare contain deductibles and co-insurances. There is a deductible for hospital benefits, and an annual deductible for medical benefits. See the "Costs" page at the front of this chapter for current amounts.

Approved charges, also known as "allowed," "accepted," "reasonable" or "eligible" charges, are those the Health Care Financing Administration has determined qualify for Medicare payment.

Only 80% of approved charges for Part B services are paid by Medicare, with the remaining 20%, and excess charges, to be paid by the beneficiary or other insurance. This 20% is referred to as a "**co-payment**", or "**co-insurance**" for Part B.

Accepting assignment means the health care provider agrees to accept Medicare's approved amount as payment in full for services delivered to a

Medicare beneficiary. Medicare pays 80% of this approved amount directly to the provider who accepts assignment; the patient, or the patient's supplemental insurance, pays the remaining 20% to the provider.

It's to the beneficiary's advantage to use "participating" health care providers who "accept assignment" on every Medicare patient's case for the entire calendar year. Many physicians and other health care providers do not accept assignment for their general practice, but will agree on a case-by-case basis to accept assignment (charge no more than Medicare-approved charges) for long-term patients or for specific types of services. It is up to the patient to get the doctor's agreement, or to verify the health care provider will accept assignment.

"Non-participating" physicians and providers deliver medical services, but do not accept assignment, except on a case by case basis. There will be a comment on the Explanation of Medicare Benefits (EOMB) form that says, "Your provider did not accept assignment".

COBRA

The Consolidated Omnibus Budget Reconciliation Act (1985) responded to the economic dislocation of workers by federally mandating requirements to extend group medical benefits to employees and their dependents under certain circumstances called "qualifying events".

In brief, COBRA provides for employees and their dependents to continue employer-sponsored health benefit plans for a period of time beyond a "qualifying event". While COBRA is not available to Medicare-eligible persons after age 65, it does apply to workers or dependents who are not yet 65 when one of the following "qualifying events" occurs:

1. **Death** of the covered employee;
2. **Termination of employment**, or reduction of hours of the covered employee to the point where the employee no longer qualifies for group health benefits;
3. **Divorce/legal separation** of the covered employee;
4. **Entitlement to Medicare** benefits by the covered employee -- the dependents under age 65 of the covered employee, who retires on social security and becomes covered by Medicare, may continue the health coverage formerly provided to them through the employer group plan. Retirement of the covered employee would be the qualifying event.

COBRA coverage can last up to eighteen months if termination or reduction of work hours is the qualifying event; in all other cases, beneficiaries (spouses and dependents) who become eligible for COBRA

benefits due to a qualifying event may obtain **up to 36 months of continuing coverage.**

Qualified beneficiaries include:

- widowed spouses and their dependent children;
- divorced or separated spouses and dependent children;
- and **Medicare ineligible** spouses and dependent children.

Coverage under the continuation plan cannot require proof of insurability and must be identical to the benefits received immediately before qualifying for continuation coverage, including vision and dental. Beneficiaries may change coverage during periods of open enrollment by the plan.

Under COBRA, the qualified beneficiary may be required to pay up to 102% of the entire premium cost, including both the employer and employee contribution to the plan plus a small service fee, but may not be charged more than regular rates for plan members.

For individuals who qualify for Social Security disability benefits, special rules apply to extend coverage an additional 11 months beyond the basic 18 months of coverage. For disabled person, the premiums may also be increased after 18 months. During the last 180 days of continuation of coverage, a conversion health plan must be offered, if one is normally available.

1996 Medicare Benefits and Gaps

(Chart outlines gaps in Medicare coverage. Refer to Medicare Handbook for complete list of Medicare benefits.)

Coverage	Beneficiary Pays	Medicare Pays
Medicare Part A		
Inpatient Hospital Care* Days 1-60 Days 61-90 Days 91-150 All additional days	\$736 deductible \$184 per day \$368 per day Everything	Balance Balance Balance Nothing
Skilled Nursing Facility Care Days 1-20 Days 21-100 All additional days	Nothing \$92 per day Everything	Everything Balance Nothing
Home Health Care**	Nothing	Up to 35 hours per week
Hospice Care	Small copayments for inpatient respite and drugs	Balance
Blood	For first 3 pints	All but first 3 pints per year
Medicare Part B		
Medical Services Medicare pays only for medically necessary services	\$100 annual deductible 20% of Medicare's approved amount Excess charges for some Part B providers	80% of Medicare's approved amount after the beneficiary pays the Part B deductible.
Durable Medical Equipment	20% of approved amount	80% of approved amount
Outpatient Hospital Treatment	20% of the billed amount (not limited to approved amount)	Medicare payment to hospital based on hospital costs
Clinical Lab Tests	Nothing for tests if medically necessary	Generally 100% of approved amount if medically necessary
Blood	For first 3 pints, plus 20% of approved amount (after \$100 deductible)	80% of approved amount (after \$100 deductible and first 3 pints per year)

* Per **benefit period** which begins upon the admission to a hospital and ends when a patient is out of a hospital or skilled nursing facility for 60 days in a row.

**Part B will pay for home health services if you do not have Part A.



A WOMAN'S GUIDE:

Medicare & Other Insurance Coverage for Mammograms

Women's lives can be saved!

It's a fact that all women are at risk for breast cancer. The risk increases as a woman gets older.

That's why regular screening is so important. A cancer found at an early stage is more likely to be cured and may need less treatment.

The good news is that Massachusetts law requires ***most insurance policies*** sold in this state to pay for mammograms.

Some facts...

A ***mammogram*** is an x-ray picture of the breast. It can show changes in breast tissue, like lumps, long before they can be felt.

A screening mammogram is usually done when you are not showing any signs of breast disease. The procedure is quick and the benefits are great.

Diagnostic mammograms are recommended and arranged by your doctor whenever symptoms are present. If you find a lump or see other changes in your breasts, see your doctor right away!

What does Medicare cover?

Screening mammograms:

If you have Medicare Part B and receive mammography services at a Medicare-approved facility, Medicare will provide coverage for early detection of breast cancer.

A screening mammogram, together with a physician's interpretation of the results, are covered by Medicare Part B at 80% of the approved charge, provided you have met the annual Medicare Part B deductible (\$100 in 1996).

The following table shows when and how often Medicare Part B will cover screening mammograms.

<u>AGE</u>	<u>FREQUENCY</u>
Under 35	No coverage
35 - 39	Baseline*
40 - 49	Every 24 months
40 - 49 (high risk)	Every 12 months
50 - 64	Every 12 months
65 and older	Every 24 months

****only one screening mammogram is allowed for women in this group***

More Medicare coverage!

Diagnostic mammograms:

Medicare also covers diagnostic mammograms whenever symptoms are present *or* if you are considered at risk for breast cancer. Unlike screenings, diagnostic mammograms are covered as often as needed provided your doctor orders them, no matter what your age is!

“Insurance coverage can be so confusing! What can I do?”

The first step is to review your health insurance policy. If you still have questions, contact the company that provides your benefits. This could be an insurance company, a plan administrator, an employer, or a government agency.

According to the state's Division of Insurance, *most health insurance policies* sold in Massachusetts are required to provide *one mammogram for women between the ages of 35 and 40, and one mammogram every 12 months for women 40 years of age and older.*

Good news!

With Medicare and a Medigap policy, women over 40 have coverage for a screening mammogram *every 12 months*. However, employer or union sponsored Blue Cross/Blue Shield Medex policies are not required to offer the state-mandated mammography benefits. Therefore, benefits may vary.

Most HMO plans, including Medicare HMOs, are also required to provide women with the state-mandated coverage for early detection screenings.

Questions to ask your insurance provider:

- ☐ Am I covered for a mammogram?
- ☐ Where can I get a mammogram?
- ☐ Do I need to go to a certain clinic?
- ☐ Do I need a referral?
- ☐ Is there a copayment or deductible?

Keep in mind, you will be responsible for any copayments or deductibles that apply. Check your policy for details!

For more information, contact the Serving Health Information Needs of Elders Program at **1-800-882-2003**.

What about Medicaid?

In Massachusetts, Medicaid will pay 100% of the cost of a mammogram every year provided your doctor has ordered the test. To learn more about Medicaid, call the MassHealth Customer Service Center at **1-800-841-2900**.

Free/Low-cost mammogram -

If you do not have medical insurance, or your health plan does not pay for *annual* screenings, you may be eligible for a free mammogram through the Breast & Cervical Cancer Initiative administered by the Massachusetts Department of Public Health. For a list of sites close to your home and to see if you qualify, call **1-800-227-2345**.

**A message to Medicare beneficiaries from the
Massachusetts Executive Office of Elder Affairs
One Ashburton Place, Boston, MA 02108
Telephone: 1-800-882-2003 or (617) 727-7750**

SPECIAL ENROLLMENT PERIOD FOR MEDICARE: (At termination of employment, or cancellation of employer group coverage)

The special enrollment period is for people aged 65+ and the disabled who have been employed and covered by an employer's health plan. It takes place, without penalty, during the 8 month period beginning with the month you are no longer covered under the employer's plan, or you (or spouse) are no longer working, whichever comes first.

Month of Termination Enroll during month, or immed. after coverage ends, A & B start with no gap.	Mo. 2	Mo. 3	Mo. 4	Mo. 5	Mo. 6	Mo. 7	Mo. 8
	—	—	—	—	—	—	—

If you are employed, and covered by your employer's group medical plan, you may wish to enroll in Medicare Part A (Hospital) because it is "premium-free." However, you may wish to delay Part B (Medical) coverage until you are no longer employed or covered by an employer's plan, whichever comes first. In most cases the employer's plan will pay first, and you will receive no benefit from enrolling in Medicare Part B. Some plans require you to enroll in Medicare to receive any benefit. **CHECK YOUR EMPLOYER'S PLAN.**

INITIAL ENROLLMENT PERIOD (for Parts A or B)

A seven month period:

- Enroll during the three months prior to month of 65th birthday, coverage starts 1st day of birthday month;
- Enroll during the month of the 65th birthday, coverage starts 1st day of following month;
- Enroll during the three months after the 65th birthday month; coverage starts two months later if enrolled in month succeeding birth month; coverage starts three months later if enrolled in second or third month after birth month.

[illegible]

GENERAL ENROLLMENT PERIOD FOR MEDICARE: (For late enrollees)

The general enrollment period is for late enrollees. The penalties for late enrollment are a permanent surcharge of 10% of the premium for each 12 month period of late enrollment, and a waiting period before Medicare Part B coverage becomes effective.

Jan	Feb	Mar	Apr	May	June	July 1st Effective Date	Aug	Sept	Oct	Nov	Dec
Enrollment period											

General enrollment takes place during January, February, and March of each year; coverage begins on July 1st of that year.

MEDICARE OVERVIEW EXERCISE

1. What agency administers the Medicare program?

2. What year did the Medicare law become effective?

3. Medicare, like Social Security, was never intended to pay 100% of a retiree's needs. T F

4. "Hospital insurance" on a Medicare card means:
Part A coverage____ or doctor coverage____

5. "Medical insurance" on a Medicare card means:
Medicaid coverage____ or Part B coverage ____

6. If a person is an American citizen and not disabled, what are the eligibility requirements for Medicare?

1. _____

2. _____

7. Describe Medicare's initial enrollment period.

8. The date of one's enrollment has no significance as far as the effective date of coverage. T F

9. Describe Medicare's general enrollment period.

10. Medicare Part B charges a 10% surcharge for each full year of late enrollment: Y N

11. Can SHINE Counselors be of value to persons nearing retirement by telling them of the Medicare sign-up requirements? Y N

12. Can "foreigners" be eligible for Medicare? Y N

Explain: _____

13. What is a Medicare "intermediary"?

14. What is a Medicare "carrier"?

15. Medicare will only pay for services that are

16. What is Medicare?

17. What are the benefits that a person would receive if they qualify for Qualified Medicare Beneficiary (QMB) Program?

18. For most Americans over the age of 65, Medicare serves as their basic health insurance foundation. T F

19. Is it possible for a person to have both Medicare and Medicaid? Y N

MEDICARE (PART A) HOSPITAL INSURANCE EXERCISE

1. Name 4 areas of Part A coverage.

a. _____

b. _____

c. _____

d. _____

2. For a person who signs up at age 65 for Medicare and is eligible for Social Security, what is the current Part A premium? _____

3. What is the current Medicare Part A deductible? _____

4. Mr. Smith enters the hospital on January 2, 1996 and stays for 20 days. He is discharged to his home and after 40 days must return to the hospital for an additional 10 days. What is his out-of-pocket costs on the hospital bill? _____

5. Which of the following services is not covered under Medicare Part A? _____

(a) Operating Room Costs

(b) Intensive Care

(c) Drugs

(d) Surgeon Charges

6. What is the lifetime maximum benefit for Medicare coverage in a certified psychiatric hospital? _____

7. The 61st - 90th day and 91st - 150th day of inpatient hospital care during a benefit period are renewable. T _____ F _____

Medicare Part A exercise(cont) -2-

8. Under what 2 circumstances will Medicare pay for a private hospital room?

a. _____

b. _____

9. While traveling as a tourist in Canada, Medicare will not pay for any Part A expenses. T _____ F _____

10. If you wish to travel overseas, what should you do about health insurance? _____

11. What conditions must be met before Medicare will pay for skilled nursing facilities care?

a. _____ d. _____

b. _____ e. _____

c. _____ f. _____

12. All nursing homes are Medicare participating skilled nursing facilities. T _____ F _____

13. What are the two levels of care that may be provided in a skilled nursing facility?

a. _____ b. _____

14. Medicare pays for all levels of care in a nursing home.

T _____ F _____

15. There are many elderly persons that need some amount of custodial care but do not need skilled nursing care.

T _____ F _____

Medicare Part A exercise (cont) -3-

16. How many days can Medicare cover during each benefit period in a SNF? _____

17. What does Medicare pay for the 21 st - 100th day in a SNF if the stay is approved? _____

18. Fifteen minutes ago, Aunt Tilley, age 78, was seen plowing the South 40 with her favorite mule. Does Aunt Tilley qualify for Medicare's Home Health Care coverage? Y _____ N _____

19. What are the requirements for Medicare Home Health coverage?

a. _____

b. _____

c. _____

20. Doctor and nursing services, homemaker services and short term respite care are services covered by: _____

a. Home health care coverage

b. Hospice coverage

c. Skilled nursing facility

21. What are Medicare's requirements for coverage of hospice care?

a. _____

b. _____

c. _____

22. A beneficiary may appeal a hospital's decision to deny continued Medicare coverage for a hospital stay.

T _____ F _____

**MEDICARE PART B
MEDICAL INSURANCE EXERCISE**

1. What type of medical services does Medicare Part B cover?

2. What is the monthly premium for Medicare Part B? _____

3. Medicare Part B coverage for eligible beneficiaries is optional.

T _____ F _____

4. The Part B calendar year deductible is _____.

5. Medicare pays 80% of approved charges on most covered Part B services. T _____ F _____

6. Explain Medicare's "approved charges."

7. Explain Medicare's "excess charges"

8. Medicare's approved charges do not keep pace with inflation and physicians charges. T _____ F _____

9. A "non-participating physician" may accept assignment on a case by case basis. T _____ F _____

10. When physicians accept assignment they accept Medicare's payment of 80% of the approved charge as payment in full for the service.

T _____ F _____

Medicare Part B exercise(cont) -2-

11. The "Physician Payment Reform" decreased a beneficiaries' out of pocket expenses under Part B.

T_____ F_____

12. Medicare will pay for medical services needed as the result of an accident even if workers compensation is responsible for making payment.

T_____ F_____

13. Medicare will pay for x-rays furnished by a chiropractor.

T_____ F_____

14. Dental care services by Medicare are very limited.

T_____ F_____

15. List several doctor's services covered under Part B.

16. Medicare will pay 80% for the cost of a "lift chair" advertised on TV without a doctor's prescription. T_____ F_____

17. Who is responsible for the portion of a physician's bill that is not paid by Medicare?_____

18. Medicare will pay for prescription drugs purchased at the local pharmacy. T_____ F_____

19. Medicare pays 80% of the approved charges for treatment of outpatient mental illness. T_____ F_____

20. If you are unhappy with your looks, Medicare will be happy to pay for a facelift. T_____ F_____

MEDICARE APPEALS AND CLAIMS PROCESSING

TOPICS

- . CLAIMS FILING - GENERAL INFORMATION**
- . MEDICARE AS A SECONDARY PAYER**
- . MEDICARE PART A CLAIMS PROCESSING**
- . MEDICARE PART B CLAIMS PROCESSING**
- . FEE LIMITS FOR PROVIDERS TREATING MEDICARE BENEFICIARIES**
- . PROCESSING PRIVATE INSURANCE CLAIMS**
- . MEDICARE APPEALS - WAIVER OF LIABILITY**
- . MEDICARE APPEALS - PART A**
- . MEDICARE APPEALS - PART B**
- . STEPS TO APPEAL - HANDOUTS FOR CONSUMERS**

Understanding Medicare and insurance paperwork is very frustrating to many older adults. Following are suggestions to consider in trying to unravel various problems with claims and reimbursement from Medicare and insurance companies.

CLAIMS FILING - GENERAL INFORMATION

1. **The rules for filing Medicare claims have changed.** After September 1, 1990, Medicare beneficiaries can no longer file any Medicare claims - Part A or B, assigned or unassigned. Now, all providers must submit the claims on behalf of the beneficiary directly to the Medicare carrier or intermediary. However, it remains the responsibility of the beneficiary to supply the provider with correct information; incorrect information delays the whole process and often results in denial of payment.
2. Check carefully that each provider has the correct Medicare number of the beneficiary receiving service. Be sure not to confuse the Medicare number with the Social Security number. The Medicare number referred to as the health insurance claim number may be the Social

Security number of someone else; also, the Medicare number always has a letter after it.

3. Check that the provider has a copy of the patient's Medicare card or in some other way knows whether the beneficiary has both Parts A and B, or only one of those parts. **Remember that one's Medicare card does not say A and B; it says Hospital Insurance and Medical Insurance.**
4. Check with the provider that the patient's name is written exactly as it is shown on the Medicare card. Nicknames or corrections, even if the spelling on the card is incorrect, will confuse the computer!
5. Be sure the provider has current addresses and telephone numbers. Sometimes Medicare will need to contact the beneficiary for additional information.
6. Should the beneficiary be deceased, contact Social Security for instructions. When a Medicare beneficiary dies, the way in which Medicare pays the doctor's or supplier's bill depends on whether the bill has already been paid, and by whom. The Carrier will explain how to claim a Part B payment reimbursement after the beneficiary has died.

MEDICARE AS THE SECONDARY PAYOR

Medicare will be the secondary payer whenever an injury has occurred which is covered and paid by a liability or no-fault insurance. This will be the case for a beneficiary seeking medical attention as a result of a work-related incident (worker's compensation), an auto accident (automobile insurance), or an injury resulting in liability claims against a homeowner (homeowner's insurance). Medicare has the right to be secondary due to subrogation laws effective after 1980.

Subrogation is the legal principle in insurance whereby an individual contractually (or by law) assigns his rights of recovery to a second

party. Subrogation prevents people from making a profit on an injury by receiving double payments. In most cases, Medicare will pay the claims for these kinds of accidents, but will ask for a refund by the third party upon settlement.

Example: *While driving his car, Mr. Smith hit Mrs. Jones while she was walking in the crosswalk. Mr. Smith is at fault and is legally liable for Mrs. Jones' injury and medical bills. Mrs. Jones' medical insurance company is the Acme Insurance Co.; it pays \$1500.00 of her medical bills while its' attorney negotiates with Mr. Smith's auto insurance company, the City Insurance Co., to pay for all of her medical bills. If the Acme Insurance company has subrogation rights, Mrs. Jones must repay \$1,500.00 to Acme when she finally receives a monetary settlement from the City Insurance company.*

Federal law requires that the injury/accident section of the claim be completed accurately.

In October 1982, Medicare instituted subrogation rights for third party liability claims of the Medicare beneficiary. Medicare has made subrogation retroactive to October 1980; therefore, it is possible that many people could be "dunned" by Medicare for back claim payments for money they have already spent.

Medicare will usually be the secondary payor if the patient has employment related insurance and may pay under some circumstances for VA related care. The Medicare beneficiary should tell the doctor, hospital and other suppliers if he or she is covered under another plan that is primary. They should provide the name and address of the plan and the policy number.

Be certain to inform the provider if the beneficiary over 65 is continuing to work. If that person is enrolled in a qualified employer health plan, it will be the primary payer for the services covered under the employer plan; Medicare would be the primary payor for Medicare covered services not

included under the employer's plan.

It is advisable for the beneficiary to give the provider his/her private Medicare supplement policy number or other insurance policy numbers.

Some Medicare supplement insurance companies will receive claims directly from Medicare after its carrier or intermediary has processed the claim. This is referred to as "**cross-over**". (Most Blue Cross/Blue Shield administered programs, such as the Medex plans, cross-over claims.)

Under federal law Medicare is authorized to ask for medical information if necessary:

- a. to identify the beneficiary
- b. to determine Medicare eligibility
- c. to determine coverage
- d. to ensure proper payment.

This information may be given to the following organizations if necessary to administer the Medicare program.

- a. Medicare intermediaries
- b. Medicare carriers
- c. Medicare medical review board
- d. doctors, hospitals, and other entities

A beneficiary may legally refuse to supply any requested information except in relation to work injuries, auto injuries, or other liability-related insurance claims as mentioned earlier. Withholding information serves no useful purpose and may result in slow payment or no payment.

MEDICARE PART A CLAIMS PROCESSING

1. Hospitals always accept assignment. They handle all paperwork and deal directly with the Medicare intermediary.

The beneficiary may receive monthly bills or statements from the hospital until the hospital is paid by Medicare or insurance. When possible, it is best to wait until insurance claims have been paid before settling the balance; **however, you must inform the hospital of your intentions to await other payment before settling the balance of the hospital bill in order to avoid problems.**

Usually, the hospital also files claims with all private insurance companies and receives those reimbursements directly, unless the private insurance is an indemnity policy; **indemnity policies which pay fixed dollar amounts per day mail their benefit checks directly to the patient.**

The patient/Medicare beneficiary may request an itemized hospital bill. However, the Medicare beneficiary is never informed as to what Medicare actually pays on that hospital claim. Instead, the beneficiary receives a **benefit notice**, also called a **utilization form**, describing days used and the deductible payment. No one should pay any hospital or provider based on the information in the Benefit Notice alone. Wait for a bill from the hospital.

- (1) Blue Cross/Blue Shield is usually the intermediary handling hospital claims from Massachusetts hospitals; for some hospital providers, Aetna Insurance Company is the intermediary.
- (2) Normally, the Medicare beneficiary receives the Benefit Notice or utilization form within sixty to ninety days after a hospitalization.

2. Medicare certified skilled nursing facilities always accept assignment and file their own Medicare claims directly with the intermediary.
 - a. The patient must be in a Medicare certified skilled nursing facility and a Medicare participating bed.
 - b. The same benefit notice used by hospitals for Part A services is used to inform beneficiaries of benefits used in the skilled nursing facility setting.
 - c. Even if the patient is not in a Medicare certified bed, he/she has the right to ask the skilled nursing facility to bill Medicare to pay for their stay and care.
 - d. As with the hospital, the patient is not informed by Medicare what actual payment was made to the facility; the patient is only told if they incurred a co-payment obligation.
 - e. Under certain circumstances, the patient may file a claim. He should contact the intermediary for that information.
3. Medicare certified Hospices and Home Health Agencies take assignments and they handle all transactions.
 - a. Payment is 100% for eligible services, except for a 20% co-payment for Durable Medical Equipment, and a small co-payment for drugs and in-patient respite.
 - b. Hospice claims are handled by Blue Cross/Blue Shield of Massachusetts, but the benefit notice is the one used for Part B hospital outpatient services.

MEDICARE PART B CLAIMS PROCESSING

1. As of September 1, 1990, all physicians and outpatient service providers are required to file all Medicare claims.

All Part B providers are not required to accept assignment. **Accepting assignment** means that the provider accepts Medicare's approved (allowed) amount as payment in full and does not try to recover the actual fee at all.

Providers accepting assignment may take up to twelve months to file claims; providers who do not accept assignment must file within 15 months.

2. In most cases, a beneficiary does not and need not file the claim himself/herself. However, if a beneficiary experiences problems because the provider refuses to file or the beneficiary is suffering financial hardship due to delayed reimbursement of out of pocket expenses, then the beneficiary can take action. He/she should notify the Medicare carrier (Blue Cross Blue Shield) and learn how to proceed; the beneficiary may be allowed to file the claim.
3. Problems and questions regarding claims can be researched by the beneficiary or SHINE counselor. Use the telephone numbers supplied by the carrier on the Explanation of Medicare Benefit forms.
4. Railroad retirees deal with a different carrier, the Travelers Insurance Company, serving regions specified in the Medicare Handbook for Railroad Retirees. The Medicare Handbook for Railroad Retirees is available from the U.S. Railroad Retirement Board, P.O. Box 2448, Boston, MA 02208-2448. Telephone: 617-565-8265.
5. Part B claims for services incurred **outside** Massachusetts must be submitted to the carrier in the state where service was provided or where the bill originated.

Beneficiaries who have residences in another state as well as Massachusetts should take special note of where the service was performed. Each state's

Part B carriers are listed in the back of the Medicare Handbook or may be supplied by Social Security, 1-800-772-1213.

6. The beneficiary will receive an Explanation of Medicare Benefits (EOMB) from the Part B carrier when the claim is paid.
 - a. The EOMB explains the billed amount which should be the same as the actual charge billed by the provider.
 - b. The EOMB explains the Medicare approved amount and then calculates what 80% of the approved fee will be. Generally, Medicare pays 80% of this approved amount.
 - c. The EOMB calculates the beneficiary's 20% co-payment amount, when applicable and the annual deductible, if not yet met.
 - d. If the claim was assigned, the EOMB will tell the recipient that the Medicare carrier mailed the check to the provider.
 - e. Unassigned claims have an EOMB with a Medicare check attached to it. The check will be made payable to the Medicare beneficiary and will be attached to the lower portion of the EOMB.
 - (1) Since it does not look like the typical check, many people do not realize that this is their payment.
 - (2) Many recipients use that check for other purposes and do not pay the provider.
 - f. The EOMB from Medicare looks like a bill, tastes like a bill, smells like a bill . . . and carries the statement: "This is not a bill . . . retain this copy for your records."
 - g. Always keep a copy of the EOMB until the matter is completely settled. It is difficult, but possible, to obtain an additional copy from the carrier.

FEE LIMITS FOR PROVIDERS TREATING MEDICARE BENEFICIARIES

1. An assignment is an agreement between Medicare, the provider (most often the physician), and the Medicare beneficiary. Some physicians sign yearly agreements with HCFA to become Medicare **participating physicians**, meaning they have agreed in advance to accept assignment on all Medicare claims. Non-participating physicians may accept assignment on a case by case basis.

2. Payment Cycles

- a. Accepting assignment means that the provider accepts Medicare's approved (allowed) amount as payment in full.

- (1) The provider sends the claim directly to Medicare, after subtracting any part of the \$100.00 annual deductible the patient has not met. *(The patient would pay any unmet deductible to the provider and this payment would be recorded upon the claim submitted to the Medicare carrier.)*
- (2) The provider is then paid directly by Medicare 80% of the approved fee for that service.
- (3) Then, the provider will bill the patient for the 20% co-insurance amount. **The beneficiary always owes 20% of the approved fee.**

- b. Not accepting assignment means that the provider does not accept Medicare's approved amount as payment in full. Instead, the provider may request the "actual charge", which very often is in excess of Medicare's approved rate. **(Massachusetts bans balance billing above the Medicare approved amount for physicians, but not other Part B providers.)**

- (1) The provider who does not accept assignment must still submit

the claim to Medicare. However, the doctor or supplier may request that the patient pay him/her directly at the time of service. Medicare pays to the patient 80% of the approved amount, after deducting any part of the patient's unmet \$100 Part B annual deductible.

Exceptions: Doctors and suppliers and certain other practitioners must take assignment on all claims for services provided to any Medicare beneficiary who is also enrolled in the Medicaid program or the Qualified Medicare Beneficiary Program (QMB).

3. Two laws set limits on physician charges to protect Medicare beneficiaries from steep excess physician charges above the Medicare approved amount. One law is federal; the second is a Massachusetts state law.
 - a. The federal law created "**Limiting Fees**" for doctors; it is a system called "**Maximum Allowable Approved Charges**" (MAAC). It sets a limit on the amount physicians may charge above Medicare's Approved Charge.
 - (1) In all states, the actual charge permitted to be charged by physicians is subject to a federal cap known as the "**limiting charge**" or the "**maximum allowable approved charge**". That fee level was set by Medicare under the Physician Payment Reform law. **Beginning in 1993, any charge from a physician who provides Part B services cannot exceed 115% of the Medicare approved charge.**
 - (2) Violations of the limiting fee law should be reported to the Medicare carrier.
 - b. In Massachusetts, a state law named the **Ban on Balance Billing** also limits physician's fees. The Ban on Balance Billing Law applies only to physicians who practice in Massachusetts and who agree to treat Medicare patients. (It is a condition of licensure.) **It limits the**

maximum fee amount they may charge to the same amount as the Medicare approved charge.

(1) Example - Ban on Balance Billing

- Suppose you receive Medicare covered services from Massachusetts doctor and ask for an itemized bill which shows the doctor's fee as \$150.00.
- The doctor submits this bill to Medicare. Subsequently, you receive an EOMB from Medicare. Medicare has determined the **reasonable approved amount** for the service to be only \$100.00.
- This means Medicare pays **80% of this amount**, equal to \$80.00.
- **You or your Medicare supplement insurance are responsible for 20% of the Medicare approved amount**, the remainder of the Medicare approved amount. (20% of \$100.00 is \$20.00).
- **DUE TO THE BAN ON BALANCE BILLING, YOU DO NOT HAVE TO PAY THE EXCESS BALANCE OF \$50.00 OVER AND ABOVE THE MEDICARE APPROVED AMOUNT.**

- c. **Second Example of Calculating the Medicare Beneficiary's Payment Obligation for Massachusetts Beneficiaries and Out-of-State Claims:** An elderly man visits a doctor for acute chest pains. The doctor diagnoses and treats his condition. The doctor's usual charge for this service is \$250.00. However, the Medicare approved amount for this service is only \$200.00.

\$250.00 = Actual amount charged (billed)

\$200.00 = Medicare Approved Amount

\$230.00 = Limiting Charge (115% of Medicare's Approved Amount)

\$160.00 = Medicare payment (80% x \$200 Approved Amount)

\$40.00 = Beneficiary's payment (20% x \$200 Approved Amount)

\$30.00 = Excess charge above Medicare's Approved Amount

Using the above factors:

- a. A provider **accepting assignment** would accept \$200.00 as his or her fee. Assignment works in this manner across the country.
 - (1) The physician will bill Medicare for \$200.00 and not request immediate payment from the beneficiary at the time of service.
 - (2) The \$230.00 charge is not requested of the recipient and the \$30.00 excess is "**written off**". It is sometimes seen on the bill as "**Medicare adjustment**".
 - (3) Medicare mails the check of \$160.00 directly to the provider.
 - (4) The beneficiary owes \$40.00 (20%) to the provider. Either the patient or the patient's private Medicare supplemental insurance would pay the provider.
- b. A provider who **does not accept assignment** and who practices in a state without any limits on balance billing could charge more than the Medicare approved amount, but not more than the federal limiting charge (\$230.00) for this claim.

- (1) If the provider does not take assignment, the beneficiary would pay \$230.00 to the provider directly at the point of service. Later, the beneficiary would receive a reimbursement check from Medicare for \$160.00, equal to 80% of the **approved charge** of \$200.00.
- (2) The beneficiary's Medicare coinsurance responsibility is \$40.00 (20% of the approved amount). If the patient has supplemental insurance, the patient's private Medicare supplemental insurance may reimburse him.
- (3) In this example, when the physician collects the permissible excess fee, then the beneficiary has a **total** out-of-pocket expense of \$70.00; \$40.00 for the Part B co-payment and \$30.00 for the additional excess charge above the Medicare approved amount.

c. **All physicians who practice in Massachusetts and treat Medicare patients cannot charge a Medicare beneficiary more than the Medicare approved amount of \$200.00.**

- (1) If the provider does not take assignment, the beneficiary would pay \$200.00 to the provider directly at the point of service. Later, the beneficiary would receive from Medicare the check of \$160.00, equal to 80% of the approved charge of \$200.00.
- (2) The beneficiary's total out of pocket responsibility to the provider is \$40.00 (20%) to the provider. Either the patient or the patient's private Medicare supplemental insurance would cover this amount of the bill.

PROCESSING PRIVATE INSURANCE CLAIMS

1. The basic Medicare supplement insurance pays a minimum of 20% of the Medicare approved amount.
 - a. Some supplement policies will pay some or all of the excess charges, that is, those charges above the Medicare approved amount. It is necessary to check the policy to know for sure what the insurance contract does pay.
2. Some employer-sponsored insurance plans are not Medicare supplements at all. They remain the same standard and/or major medical policy as was available when the retiree was working. These policies will usually assume (and require) that the beneficiary have Medicare Parts A and B. It becomes important to know that fact because these policies will "carve out" the Medicare payment from their own reimbursement, whether or not the beneficiary actually has subscribed to Medicare. This is true, for example, of the Blue Cross/Blue Shield Plan to which City of Boston employees subscribe.
3. Virtually all private insurance require the policyholder to submit the Part B Medicare EOMB or the Part A Benefit Notice before they will reimburse for the claim. Some also require a bill from the provider and their own claim form.

Here is the filing process:

- a. Provider files claim with Medicare. Medicare beneficiary must wait to receive the Explanation of Medicare Benefits (EOMB).
- b. Attach Medicare EOMB to Medicare supplement insurance claim form supplied by the insurance company.
- c. Attach the actual bill for that service (if required by insurance carrier).

- d. Complete the Medical Claims Payment Record for the claim.
 - e. Make copies of the entire packet for your records.
 - f. Mail all items in envelope supplied by the insurance company to insure prompt processing.
 - g. Never send your only copy. Papers often are lost and it is very difficult to replace them, especially EOMBs.
4. Most benefits covered by Medicare supplement insurance are paid based on Medicare eligible charges; hence, if Medicare does not pay for the service, neither will the private insurance. Some supplements do have exceptions and will pay benefits, regardless of Medicare, for nursing home stays, private duty nursing, mammograms in Medicare's off year, foreign travel, and prescriptions. Read the policy for such details.

MEDICARE APPEALS

1. Waiver of Liability Defense Against Unexpected Liability for Medical Costs

Part A - Common Principles / Different Appeal Avenue

- a. Liability of the Provider - If the services provided would ordinarily be covered, but were found to be medically unnecessary or constituted custodial care, **liability** for the cost of the care **falls on the Part A provider** if it is determined that the provider knew or could have reasonably been expected to know that the items or services were not covered by Medicare.
- b. Medicare's Liability - The **Medicare program accepts liability** if the provider did not know nor could not reasonably have been expected to know that the services were not covered.

- c. Sometimes, a beneficiary is billed for services which he/she believed were covered by Medicare. Unless the provider forewarns the beneficiary that a service or procedure is not covered by Medicare, the beneficiary cannot be held liable for the cost of rendering that service.
 - (1) To appeal Medicare's decision to deny payment about a Part A service, the beneficiary must submit a **"Request For Reconsideration"** either through the Social Security Administration or the Medicare intermediary,
 - (2) The request for a Reconsideration must be made within 60 days of receipt of the Medicare determination which denied coverage.

2. **Part B - Medical Insurance Claims**

- a. The provider would be liable (cannot request payment from a patient) if the provider led the beneficiary to believe that Medicare would cover a service or if the beneficiary could not have known the service would not be covered. The waiver of liability provision protects the beneficiary.
- b. The carrier and physician have the burden of proving that the beneficiary knew that the services would not be covered.
- c. The beneficiary may request a review by writing a letter to the carrier or submitting to the carrier a **"Request for Review Part B Medicare Claim"** form. This review request must be done within six months of the claim processing date found on the EOMB form.
- d. If the appeal is successful and the beneficiary has already paid the bill, Medicare will be responsible for obtaining a refund or paying the beneficiary directly.
- e. Providers use informed consent forms to avoid bearing these costs.

MEDICARE APPEALS - PART A

Appealing Hospital Discharge

When a beneficiary is admitted to a Medicare certified hospital, the beneficiary should receive a form entitled, "**Important Message from Medicare**". This statement outlines the patient's rights as a Medicare patient.

- (1) When a beneficiary thinks he or she is being discharged prematurely; the beneficiary should definitely request a written **Notice of Non-Coverage** because it explains the appeal rights of Medicare hospital patients who believe they are being discharged too soon. A premature discharge is, in effect, a partial denial of benefits.
- (2) When a beneficiary is notified orally that they will be discharged, a beneficiary should request an official, written **Notice of Non-Coverage** from a hospital representative if it has not been provided. Hospitals must provide this notice to all Medicare beneficiaries.

A patient is financially responsible for all services beginning on the third day after the receipt of this Notice of Non-Coverage **unless the patient requests an immediate review by MassPRO**. Similarly, if the patient receives a Discharge Notice, they can appeal the discharge notice by contacting MassPRO and requesting an appeal.

To request an immediate review of the decision to terminate hospital coverage, you must contact MassPRO by telephone at 617-890-0011 or 1-800-252-5533 before 12:00 noon of the first working business day after the receipt of the Notice of Non-Coverage. This is called an "**expedited review**".

The **Notice of Non-Coverage** outlines the appeal process for opposing the hospital's decision to discharge a patient. The appeal is handled through the **Massachusetts Peer Review Organization** (MassPRO or PRO). MassPRO, a federally designated peer review

organization staffed by doctors and nurses, reviews the care provided to Medicare patients in Massachusetts. The PRO must assure that the care is medically necessary and appropriate, meets the requirements for coverage by Medicare, and is of a quality consistent with recognized standards of care.

The PRO has until 5:00 P.M. of the day following the request to review the situation and make a determination. The PRO will either agree or disagree with the discharge notice. Medicare, not the beneficiary, is responsible for any hospital charges while the PRO is conducting its review.

- a. MassPRO will send the patient a formal letter called the "Notice of Medicare Initial Determination"; the determination will state whether a continued hospitalization was appropriate or medically necessary or that the beneficiary no longer requires a hospital level of care. It will also inform the Medicare beneficiary of his or her right to appeal this determination in a process called the **Reconsideration**.
- b. If the PRO agrees with the hospital, and the patient wants to appeal, the patient has 60 days from the date of the initial determination to submit a **Request for Reconsideration** to MassPRO. At this stage, the Massachusetts Medicare Advocacy Project legal staff should be brought in to carry forward with the Reconsideration and subsequent appeals.
- c. If the PRO agrees with the hospital, the patient will not be financially responsible for any services received until after noon of the next day after the patient received MassPRO's initial determination.

So, if the beneficiary requests an additional appeal (the Reconsideration) and the PRO still agrees with the discharge decision, she or he would be financially responsible for any

hospital costs incurred during the second appeal.

REMINDER: This appeals process for opposing a hospital discharge notice is outlined in the both the "**Important Message**" and "**Notice of Non-Coverage**" letters which hospitals must give to every Medicare patient.

Appealing Denial or Partial Denial of Benefits In a Nursing Home Setting

Medicare's very restrictive eligibility requirements severely limit Medicare payments for nursing home care. Usually, the nursing home will know whether the patient's illness or treatment will qualify for payment, but sometimes it is denied payment unexpectedly. Therefore, the skilled nursing facilities try to anticipate when the Medicare level of skilled care will cease. They must notify the patient that the continued services provided in the SNF will be viewed as not reasonable or unnecessary under Medicare standards for coverage and payment.

At the end of this Chapter there is a sample letter from a nursing home to a patient which outlines a patient's options once their continued stay and care in the nursing facility appears to be uncovered by Medicare. Please refer to it when reviewing this section.

To summarize, the patient can ask the nursing home to submit a **demand bill** to Medicare for the potentially non-covered services without regard to whether or not the SNF states "**Medicare will no longer consider your care skilled...**"

Medicare would then issue a denial in a formal determination. That formal determination must be received before the patient has a right to appeal.

During this demand billing cycle, the patient is not required to pay for services which **could** potentially be covered by Medicare until a Medicare

decision (the "determination") has been made.

Be sure to have a thorough understanding of the patient's right to request a demand bill and the patient's responsibility to pay privately to the nursing home if the judgment of the nursing home is not tested in such a case.

Appealing Denial or Partial Denial of Part A Benefits (Hospital, SNF, or Home Health Agency)

After the beneficiary has been discharged, he will receive an a Medicare determination that their services are not covered. This statement will outline reasons why, if any, certain items are disallowed, or he may receive a disallowance letter (when coverage is denied).

If the beneficiary disagrees with this Medicare determination, she/he may request a "**Reconsideration**". A written request for a reconsideration must be sent to either the Social Security Administration or the Medicare Intermediary within 60 days of receipt of the determination/denial of coverage.

If the beneficiary disagrees with the reconsideration determination, he may within 60 days request a hearing before an **Administrative Law Judge**. The request is submitted to the SSA. The beneficiary may appear at the hearing alone or with a representative. The amount in dispute must be at least \$100.00. The ALJ hearing is informal, but all testimony is taken under oath or affirmation and is recorded.

If the beneficiary is not satisfied with the ALJ's decision, he may request a review from the Appeals Council by using a special form available from his local Social Security office. Again, the appeal request must be submitted within 60 days. The Appeals Council is based in Arlington, Virginia.

If the beneficiary disagrees with the Appeals Council's decision or the request for review by the Council is denied, then the beneficiary may file a civil action in a U.S. District Court for the judicial district where he lives. The amount in controversy must exceed \$1,000 if the appeal involves a skilled nursing facility, a home health agency, or a hospice. The amount in controversy must exceed \$2,000 if it involves a DRG inpatient appeal.

MEDICARE APPEALS - PART B

If a beneficiary receives a denial for Part B-type services, or receives an EOMB containing confusing information, the beneficiary can contact the Medicare carrier and ask for an explanation. The claim may need to be resubmitted if incorrect information appeared on it.

If the beneficiary still disagrees with the claim settlement, then she/he may request a review.

- a. A request for a review may be in the form of a letter, a form titled **"Request for Review of Part B Medicare Claim"** (obtainable from the SSA), or a request written directly onto an EOMB form. One of these documents requesting a review must be mailed to the carrier.
- b. The beneficiary must request this review within **six months** of the claims processing date found on the EOMB form.
- c. During this review phase, the carrier examines only records, documents, and other written information. There is no opportunity for face to face meetings during the review. Therefore, the beneficiary must supplement the request for review with additional information.
- d. The carrier will send a notice to the beneficiary or representative explaining the decision. If the decision favors the beneficiary, the appeal ends and Medicare will correct the mistake. If the decision goes against the beneficiary, he may request a **hearing**.

A hearing is the second level in the Part B appeals process. The beneficiary may request a hearing by completing the **"Request for Hearing"** form (this form may be obtained from the SSA) or by a letter addressed to the Part B carrier.

- a. The request for hearing must be made within six months from the notification date of the review decision. Extensions may be granted for good cause.
 - b. The amount in dispute must be \$100.00 or more. The beneficiary may combine other disputed claims together in order to have a total greater than \$100.00.
 - c. The carrier will acknowledge the request for hearing and then set a date, time and place for the hearing. The beneficiary will be notified at least 14 days before the scheduled date. Another person (a friend, attorney, or relative, for example) may represent the beneficiary at the hearing. The hearing is informal, with the hearing officer asking questions of the beneficiary or a person representing the beneficiary or any witnesses on the beneficiary's behalf. The hearing officer will accept most types of evidence for consideration.
 - d. If the beneficiary disagrees with the carrier hearing decision and the amount in question is \$500 or more, a hearing before an Administrative Law Judge may be requested.
 - (1) This request can be made through the Part B carrier or the Health Care Financing Administration.
 - (2) Cases involving \$1,000 or more can eventually be appealed to a Federal Court, after review by the appeals council.
4. Free legal representation is available to Massachusetts Medicare beneficiaries with Medicare issues. The **Massachusetts Medicare Advocacy Project (MMAP)** provides free legal advice and assistance for filing and pursuing Medicare reviews, reconsideration and appeals. The Medicare Advocacy Project has offices across the state; the telephone number for the central office is 1-800-323-3205; other regional office telephone numbers are listed on the brochure on the next page.

All About MAP

- Since its creation in 1985, the **Massachusetts Medicare Advocacy Project** has provided *advice and free legal representation* to thousands of elderly and disabled Massachusetts residents who have been wrongfully denied Medicare coverage.
- During the last fiscal year, **MAP** won more than \$850,000 in *Medicare benefits* that had been illegally denied or terminated. **MAP** was successful in more than 90 percent of its administrative appeals.
- **MAP** provides the services of *attorneys and paralegals who are experienced in Medicare advocacy.*
- Throughout its existence, **MAP** has engaged in *major outreach efforts.* These include outreach to Medicare beneficiaries and training for employees of social service agencies, long-term care facilities, and home-health agencies.
- **MAP** is funded by the *Massachusetts Legal Assistance Corporation* with appropriated funds from the Legislature.

The Massachusetts Medicare Advocacy Project has offices in six convenient locations:

BOSTON

Serving Essex, Middlesex, Norfolk and Suffolk counties.
Greater Boston Legal Services
197 Friend Street, 02114
(617) 371-1234 Toll-free: 800-323-3205

HYANNIS

Serving Barnstable, Dukes and Nantucket and Plymouth counties.
Legal Services for Cape Cod and Islands
460 W. Main Street, 02601
(508) 775-7020 Toll-free: 800-742-4107

LAWRENCE

Serving Essex and Middlesex counties.
Merrimack Valley Legal Services
11 Lawrence Street, Suite 324, 01840
(508) 687-1177 Toll-free: 800-427-2521

NEW BEDFORD

Serving Bristol and Plymouth counties.
Southeastern Massachusetts Legal Assistance Corporation
21 South Sixth Street, 02740
(508) 996-8576 Toll-free: 800-244-9023

SPRINGFIELD

Serving Franklin, Hampden, Berkshire, and Hampshire counties.
Western Massachusetts Legal Services
145 State Street, 01103
(413) 781-7814

WORCESTER

Serving Worcester county.
Legal Assistance Corporation of Central Massachusetts
405 Main Street, 4th floor, 01608
(508) 752-3718 Toll-free: 800-649-3718

Produced by the Massachusetts Medicare Advocacy Project
July, 1995

Do You Have Medicare Troubles?

We Can Help You

The Massachusetts
**MEDICARE ADVOCACY
PROJECT**

offers advice and
free legal representation to
Massachusetts
Medicare beneficiaries.

Explanation of Your Medicare Part B Benefits

TEST NHAMP
1 JACOB ST
BOSTON MA 02128-2710

Summary of this notice dated August 29, 1995

Total charges:	\$	100.00
Total Medicare approved	\$	81.40
We paid your provider:	\$	0.00
Your total responsibility:	\$	81.40

Your Medicare number is: 699-22-8816B

Your provider accepted assignment.

Details about this notice (See the back for more information.)

BILL SUBMITTED BY: Alan J. Burbank M.D. (NH4173)
Mailing address: 289 Main Street, Salem, NH 03079-2731

<u>Dates</u>	<u>Services and Service Codes</u>	<u>Charge</u>	<u>Medicare Approved</u>	<u>See Not Below</u>
Jul 7, 1995	Claim control number 24-95241-100-010 1 Office/outpatient visit, est (99215)	\$ 100.00	\$ 81.40	a

Notes:

- a The approved amount is based on the fee schedule.
- b Because you assigned Medigap benefits, information regarding your claim will be sent to your private insurer within 30 days. Send any questions regarding your Medigap benefits to them.

GENERAL INFORMATION ABOUT MEDICARE:

Get a Mammogram--A picture that can save your life. Your physician or carrier can provide information on this Medicare covered service.

The flu season is approaching. Now is a good time to make plans for your annual flu shot. Please remember that flu shots are now covered by Medicare.

IMPORTANT: If you have questions about this notice call C&S Administrative Services at 1-800-447-1142 or 1-207-828-4300 or visit us at 2 1/2 Beacon St, Concord, NH 03301. If you want, you can mail your questions to P Box 1000, Hingham, Ma 02044. You'll need this notice when you call or visit us.

To appeal our decision, you must WRITE to us before February 29, 1996. See #2 on the back.

25 SHAW

Important Information You Should Know About Your Medicare Part B Benefits

This part of the notice answers some questions about receiving Medicare payments. If you have other questions, see your copy of *The Medicare Handbook* or call us for more information.

1. What should I do if I have questions about this notice?

If you have questions about this notice, call, write or visit us and we will tell you the facts that we used to decide what and how much to pay. Turn to the front of this notice; our address and phone number are on the bottom of the page.

2. Can I appeal how much Medicare paid for these services?

If you do not agree with what Medicare approved for these services, you may appeal our decision. To make sure that we are fair to you, we will not allow the same people who originally processed these services to conduct this review.

However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late (for example, if you had an extended illness which kept you from being able to file on time).

Turn to the front of this notice, the deadline date and our address are on the bottom of the page. It may help your case if you include a note from your doctor or supplier (provider) that tells us what was done and why.

If you want help with your appeal, or if you have questions about Medicare, you can have a friend or someone else help you. There are also groups, such as legal aid services, who will provide free advisory services if you qualify. In addition, volunteers at Medicare peer counseling programs in your area can also provide you with assistance. If you would like more information on how to get in touch with a counselor, contact us at the address or phone numbers on the bottom of the front page of this notice.

3. How much does Medicare pay?

The details on the front of this notice explain how much Medicare paid for these services. See your copy of *The Medicare Handbook* for more information about the benefits you are entitled to as a beneficiary in the Medicare Part B program. If you need another copy of the handbook, call or visit your local Social Security Office.

Medicare may make adjustments to your payment. We may reduce the amount we pay for services by a certain percentage (Balanced Budget Law). If your provider accepted assignment, you are not liable to pay the amount of this reduction. We pay interest on some claims not paid within the required time.

All Medicare payments are made on the condition that you will pay Medicare back if benefits are also paid under insurance that is primary to Medicare. Examples of other insurance are employer group health plans, automobile medical, liability, no fault or workers' compensation. Notify us immediately if you have filed or could file a claim with insurance that is primary to Medicare.

4. How can I reduce my medical costs?

Many providers have agreed to be part of Medicare participation program. That means that they will always accept the amount that Medicare approved as their full payment. Write or call us for the name of a participating provider or for a free list of participating providers.

A provider who accepts assignment for covered services can charge you only for the part of the annual deductible you have not met and the copayment which is 20 percent of the approved amount.

If you are treated by one of these doctors, you can save money. See *The Medicare Handbook* for more information about how you can reduce your medical costs.

Generally a doctor who has not accepted assignment may not charge more than 115 percent of the Medicare approved amount for services provided in 1993 or later. This is known as the limiting charge. Contact us if assignment was not accepted and you think your doctor charged more than the limiting charge.

Some states have laws that could further reduce your Medicare costs. Please see *The Medicare Handbook* published in 1993 or later for more information.

5. How can I use this notice?

You can use this notice to:

- Contact us immediately if you think Medicare paid for a service you did not receive;
- Show your provider how much of your deductible you have met;
- Claim benefits with another insurance company. If you send this notice to them, make a copy of it for your records.

More details about this notice**Here's an explanation of this notice:**

Of the total charges, Medicare approved	\$ 81.40
Less the deductible applied	- 81.40
Approved amount less deductible	\$ 0.00
Medicare owes	\$ 0.00
We are paying the provider	\$ 0.00

Of the approved amount	\$ 81.40
Less what Medicare owes	- 0.00
Your total responsibility	\$ 81.40

Your provider agreed to accept this amount. See #4 on
You have met \$ 81.40 of your \$100.00 deductible for
Medicare pays 80% of this total.

The provider may bill you for this amount.

IMPORTANT: If you have questions about this notice call C&S Administrative Services at 1-800-447-1142 or 1-207-828-4300 or visit us at 2 1/2 Beacon St, Concord, NH 03301. If you want, you can mail your questions to P Box 1000, Hingham, Ma 02044. You'll need this notice when you call or visit us.

To appeal our decision, you must WRITE to us before February 29, 1996. See #2 on the back.

26 SHINE

Important Information You Should Know About Your Medicare Part B Benefits

This part of the notice answers some questions about receiving Medicare payments. If you have other questions, see your copy of *The Medicare Handbook* or call us for more information.

1. What should I do if I have questions about this notice?

If you have questions about this notice, call, write or visit us and we will tell you the facts that we used to decide what and how much to pay. Turn to the front of this notice; our address and phone number are on the bottom of the page.

2. Can I appeal how much Medicare paid for these services?

If you do not agree with what Medicare approved for these services, you may appeal our decision. To make sure that we are fair to you, we will not allow the same people who originally processed these services to conduct this review.

However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late (for example, if you had an extended illness which kept you from being able to file on time).

Turn to the front of this notice, the deadline date and our address are on the bottom of the page. It may help your case if you include a note from your doctor or supplier (provider) that tells us what was done and why.

If you want help with your appeal, or if you have questions about Medicare, you can have a friend or someone else help you. There are also groups, such as legal aid services, who will provide free advisory services if you qualify. In addition, volunteers at Medicare peer counseling programs in your area can also provide you with assistance. If you would like more information on how to get in touch with a counselor, contact us at the address or phone numbers on the bottom of the front page of this notice.

3. How much does Medicare pay?

The details on the front of this notice explain how much Medicare paid for these services. See your copy of *The Medicare Handbook* for more information about the benefits you are entitled to as a beneficiary in the Medicare Part B program. If you need another copy of the handbook, call or visit your local Social Security Office.

Medicare may make adjustments to your payment. We may reduce the amount we pay for services by a certain percentage (Balanced Budget Law). If your provider accepted assignment, you are not liable to pay the amount of this reduction. We pay interest on some claims not paid within the required time.

All Medicare payments are made on the condition that you will pay Medicare back if benefits are also paid under insurance that is primary to Medicare. Examples of other insurance are employer group health plans, automobile medical, liability, no fault or workers' compensation. Notify us immediately if you have filed or could file a claim with insurance that is primary to Medicare.

4. How can I reduce my medical costs?

Many providers have agreed to be part of Medicare participation program. That means that they will always accept the amount that Medicare approves as their full payment. Write or call us for the name of a participating provider or for a free list of participating providers.

A provider who accepts assignment for covered services can charge you only for the part of the annual deductible you have not met and the copayment which is 20 percent of the approved amount.

If you are treated by one of these doctors, you can save money. See *The Medicare Handbook* for more information about how you can reduce your medical costs.

Generally a doctor who has not accepted assignment may not charge more than 115 percent of the Medicare approved amount for services provided in 1993 or later. This is known as the limiting charge. Contact us if assignment was not accepted and you think your doctor charged more than the limiting charge.

Some states have laws that could further reduce your Medicare costs. Please see *The Medicare Handbook* published in 1993 or later for more information.

5. How can I use this notice?

You can use this notice to:

- Contact us immediately if you think Medicare paid for a service you did not receive;
- Show your provider how much of your deductible you have met;
- Claim benefits with another insurance company. If you send this notice to them, make a copy of it for your records.

THIS IS NOT A BILL

Explanation of Your Medicare Part B Benefits

JOHN D DOE
APARTMENT 12 C
63 WOODLAWN DRIVE
BALTIMORE, MARYLAND 21207-1111

Summary of this notice dated February 1, 1994

Total Charges:	\$ 300.00
Total Medicare approved:	\$ 180.00
We are paying you:	\$ 144.00
Your total responsibility:	\$ 207.00

Your Medicare number is: 123-45-6789A

Your provider did not accept assignment

Details about this notice

Control number 0000-0000-0000

BILL SUBMITTED BY: Elm Street Clinic
Mailing Address: 123 Elm Street, Baltimore, MD 21228

<u>Dates</u>	<u>Services and Service Codes</u>	<u>Charges</u>	<u>Medicare Approved</u>	<u>See Notes Below</u>
Jan 10, 1994	Dr. Mary Smith 3 office visits [00000]	\$ 300.00	\$ 180.00	a, b

Your provider did not accept assignment. We are paying you the amount that we owe you.

Notes:

- a The approved amount is based on the fee schedule
- b Your doctor did not accept assignment for this service. Under federal law, your doctor cannot charge more than \$207.00.

Here's an explanation of this notice:

Of the total charges. Medicare approved	\$180.00
Your 20%	- 36.00
The 80% Medicare pays	\$144.00
We are paying you	\$144.00

Your co-payment is 20%

Of the total charges	\$300.00
Less amount exceeding charge limit	- 93.00

You are not responsible for this amount which is in excess of the Medicare limiting charge.

The total you are responsible for	\$207.00
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The provider may bill you for this amount.

IMPORTANT: If you have questions about this notice, call (carrier name) at (carrier telephone number) or see us at (carrier walk-in address). You will need this notice if you contact us.

To appeal our decision, you must WRITE to us before August 1, 1994.

27 SHIN

THIS IS NOT A BILL

DATE: 03/08/95

PAGE 1

YOUR MEDICAL NUMBER	
HEALTH INSURANCE CLAIM NUMBER	
ALWAYS USE THIS NUMBER WHEN WRITING ABOUT YOUR CLAIM	

SOME OR ALL OF THE CLINICAL/DIAGNOSTIC LAB SERVICES BILLED MAY BE EXEMPT FROM DEDUCTIBLE AND/OR COINSURANCE

CONTROL NUMBER 1505936641

OUR RECORDS SHOW YOU RECEIVED SERVICES FROM → 220119	PROVIDER NAME, ADDRESS AND STATE FAULKNER HOSPITAL 1153 CENTRE ST JAMAICA PLAIN MA 02130-3492		DATE OF FIRST SERVICE 02/07/95
			LAST SERVICE 02/07/95
TYPE OF SERVICE	COVERED CHARGES	REMARKS	
NO MEDICARE REIMBURSEMENT BECAUSE - CHARGES COVERED UNDER GROUP HEALTH DIAGNOSTIC LABORATORY SERVICES EMERGENCY VISITS # 1 EKG/ECG SERVICES	81.00 136.00 71.00		
A. TOTAL COVERED CHARGES	0.00	1. \$ _____ OF YOUR _____ DEDUCTIBLE NOW MET FOR _____	
B. \$ 0.00 COUNTED TOWARD YOUR PART B CASH DEDUCTIBLE	0.00	ALL AMOUNTS PAYABLE BY YOU SHOULD BE PAID DIRECTLY TO THE PROVIDER. DO NOT SEND PAYMENT TO BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS	
C. \$ 0.00 PART B BLOOD DEDUCTIBLE CHARGE			
D. \$ 0.00 COINSURANCE, 20% OF (A, MINUS SUM B + C)			
E. \$ 0.00 TOTAL DEDUCTIBLE AND COINSURANCE PAYABLE BY YOU			
F.		2. 0.00	← AMOUNT YOU PAID PROVIDER
G.		3. 0.00	← AMOUNT OWED PROVIDER
H.		4. 0.00	← REFUND (ENCLOSED)
I. BALANCE OF COVERED CHARGES	0.00	← MEDICARE PAID FOR THESE SERVICES	

PLEASE READ OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION

78 541



PLEASE READ OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION

THIS IS NOT A BILL

DATE: 05/20/91 PAGE

YOUR MEDICAL NUMBER
HEALTH INSURANCE CLAIM NUMBER
ALWAYS USE THIS NUMBER WHEN WRITING ABOUT YOUR CLAIM

CONTROL NUMBER 1110527715

OUR RECORDS SHOW
YOU RECEIVED
SERVICES FROM.....
340114

PROVIDER NAME, ADDRESS AND STATE

REX HOSPITAL
4420 LAKE BOONE TRAIL
RALEIGH NC 27607

DATE OF FIRST SERVICE

03/04/91

LAST SERVICE

03/31/91

TYPE OF SERVICE	COVERED CHARGES	REMARKS
PHYSICAL, SPEECH OR OCCUP. THERA	672.00	
TOTAL COVERED CHARGES	672.00	1. 100.00 OF YOUR 100.00 DEDUCTIBLE NOW MET FOR 1991
\$ 0.00 COUNTED TOWARD YOUR PART B CASH DEDUCTIBLE		
\$ 0.00 PART B BLOOD DEDUCTIBLE CHARGE		ALL AMOUNTS PAYABLE BY YOU SHOULD BE PAID DIRECTLY TO THE PROVIDER. DO NOT SEND PAYMENT TO NORTH CAROLINA BLUE CROSS & BLUE SHIELD.
\$ 134.40 COINSURANCE, 20% OF (A, MINUS SUM OF B + C)		
\$ 134.40 TOTAL DEDUCTIBLE AND COINSURANCE PAYABLE BY YOU	134.40	2. 0.00 AMOUNT YOU PAID PROVIDER
		3. 134.40 AMOUNT OWED PROVIDER
		4. 0.00 REFUND (ENCLOSED)
BALANCE OF COVERED CHARGES	537.60 MEDICARE PAID FOR THESE SERVICES

PLEASE READ OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION

29 SHINE

An Important Message From Medicare

Your Rights While You Are A Medicare Hospital Patient

- You have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your discharge date must be determined solely by your medical needs, not by "Diagnosis Related Groups" (DRGs) or Medicare payments.
- You have the right to be fully informed about decisions affecting your Medicare coverage and payment for your hospital stay and for any post-hospital services.
- You have the right to request a review by a Peer Review Organization (PRO) of any written *Notice of Noncoverage* that you receive from the hospital stating that Medicare will no longer pay for your hospital care. PROs are groups of doctors who are paid by the Federal Government to review medical necessity, appropriateness and quality of hospital treatment furnished to Medicare patients. The phone number and address of the PRO for your area are:

Talk To Your Doctor About Your Stay In The Hospital

You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. If you have any questions about your medical treatment, your need for continued hospital care, your discharge, or your need for possible post-hospital care, don't hesitate to ask your doctor. The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

If You Think You Are Being Asked To Leave The Hospital Too Soon

- Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a *Notice of Noncoverage*. You must have this *Notice of Noncoverage* if you wish to exercise your right to request a review by the PRO.
- The *Notice of Noncoverage* will state either that your doctor or the PRO agrees with the hospital's decision that Medicare will no longer pay for your hospital care.
 - If the hospital and your doctor agree, the PRO does not review your case before a *Notice of Noncoverage* is issued. But the PRO will respond to your request for a review of your *Notice of Noncoverage* and seek your opinion. You cannot be made to pay for your hospital care until the PRO makes its decision, if you request the review by noon of the first work day after you receive the *Notice of Noncoverage*.
 - If the hospital and your doctor disagree, the hospital may request the PRO to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation the PRO must agree with the hospital or the hospital cannot issue a *Notice of Noncoverage*. You may request that the PRO reconsider your case after you receive a *Notice of Noncoverage*, but since the PRO has already reviewed your case once, you may have to pay for at least one day of hospital care before the PRO completes this reconsideration.

IF YOU DO NOT REQUEST A REVIEW, THE HOSPITAL MAY BILL YOU FOR ALL THE COSTS OF YOUR STAY BEGINNING WITH THE THIRD DAY AFTER YOU RECEIVE THE *NOTICE OF NONCOVERAGE*. THE HOSPITAL, HOWEVER, CANNOT CHARGE YOU FOR CARE UNLESS IT PROVIDES YOU WITH A *NOTICE OF NONCOVERAGE*.

How To Request A Review Of The Notice Of Noncoverage

- If the *Notice of Noncoverage* states that your physician agrees with the hospital's decision:
 - You must make your request for review to the PRO by noon of the first work day after you receive the *Notice of Noncoverage* by contacting the PRO by phone or in writing.
 - The PRO must ask for your views about your case before making its decision. The PRO will inform you by phone or in writing of its decision on the review.
 - If the PRO agrees with the *Notice of Noncoverage*, you may be billed for all costs of your stay beginning at noon of the day after you receive the PRO's decision.
 - Thus, you will not be responsible for the cost of hospital care before you receive the PRO's decision.
- If the *Notice of Noncoverage* states that the PRO agrees with the hospital's decision:
 - You should make your request for reconsideration to the PRO immediately upon receipt of the *Notice of Noncoverage* by contacting the PRO by phone or in writing.
 - The PRO can take up to three working days from receipt of your request to complete the review. The PRO will inform you in writing of its decision on the review.
 - Since the PRO has already reviewed your case once, prior to the issuance of the *Notice of Noncoverage*, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your *Notice of Noncoverage* even if the PRO has not completed its review.
 - Thus, if the PRO continues to agree with the *Notice of Noncoverage*, you may have to pay for at least one day of hospital care.

NOTE: The process described above is called "immediate review." If you miss the deadline for this immediate review while you are in the hospital, you may still request a review of Medicare's decision to no longer pay for your care at any point during your hospital stay or after you have left the hospital. The *Notice of Noncoverage* will tell you how to request this review.

Post-Hospital Care

When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or home care. The discharge planner at the hospital will help arrange for the services you may need after your discharge. Medicare and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult with your doctor, hospital discharge planner, patient representative, and your family in making preparations for care after you leave the hospital. Don't hesitate to ask questions.

Acknowledgement of Receipt - My signature only acknowledges my receipt of this Message from (name of hospital) on (date) and does not waive any of my rights to request a review or make me liable for any payment.

Signature of beneficiary or person acting on behalf of beneficiary

Date of receipt

NOTICE OF NONCOVERAGE

Date: _____

(Admission Date)

(HIC No.)

(Attending Physician)

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

The _____ Hospital has reviewed the medical services you have received for STROKE (CVA)

from 10/12/93 through 11/2/93 and has determined that further hospitalization is not necessary. Specific provisions of the Medicare law allow you to stay in the hospital even if you do not require inpatient hospital care if both of the following conditions are met:

1. You require a skilled nursing facility level of care, and
2. A skilled nursing facility bed is not available for you in a Medicare participating skilled nursing facility in the local geographic area.

The _____ Hospital has determined that the above provision does not apply to you because:

- ☒ You do not require a skilled nursing facility level of care.
- ☐ You have declined to accept a skilled nursing facility bed offered to you in a Medicare participating skilled nursing facility in your geographic area.

Your attending physician has been advised and has concurred that beginning 11/2/93 that further services to be rendered or your medical
(Date)

condition to be treated either are deemed medically unnecessary or could be rendered safely in other than a hospital or SNF setting. This determination was based upon the Melrose-Wakefield Hospital's understanding and interpretation of available Medicare coverage policies and guidelines.

You are financially liable for all costs of the care you receive, except for those services for which you are eligible under Part B, beginning on ** 11/5/93, the date of the third day following the date of receipt of the hospital notice. You should discuss with your attending physician other arrangements for any further health care you may require.

However, this notice is not an official Medicare determination. MassPRO is the peer review organization (PRO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the Commonwealth of Massachusetts and to make that determination.

IF YOU DISAGREE WITH OUR CONCLUSION:

Request immediately, by noon of the first working day after receipt of this notice, an immediate review by telephone, or in writing. You may make this request through the hospital or directly to MassPRO at the address listed below.

The PRO will request your views about your case and respond to you within one working day of receipt of your medical records (sent by the hospital).

IF YOU DO NOT REQUEST REVIEW BY NOON OF THE FIRST WORKING DAY AFTER RECEIPT OF THIS NOTICE:

You may still request PRO review at any point during your hospital stay or within 30 calendar days after you receive this notice, whichever is longer. Request this PRO review at the address listed below.

PRO REVIEW RESULTS:

The PRO will send you a formal determination of the medical necessity and appropriateness of your hospitalization and will inform you of your reconsideration rights.

IF MASSPRO DISAGREES WITH THE HOSPITAL: (i.e., it determines that your care is covered by Medicare): you will be refunded any amount collected by the hospital except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare.

** Physical Therapy Discontinued

IF MASSPRO AGREES WITH THE HOSPITAL:

You are responsible for payment of all services beginning on 11/5/93,
the date of the third day following the date of receipt of the hospital notice
unless you request an immediate review.

If you request an immediate review (i.e., you make your request for review by
noon of the first working day after receipt of this notice) you will not be
responsible for payment until noon of the next day after you receive the PRO's
notification.

MASSPRO ADDRESS:

MassPRO
300 Bear Hill Road
Waltham, MA 02254
Attn: Reconsideration Dept.

(617) 890-0011
or
1-800-252-5533

Sincerely,

Utilization Review Physician Advisor
Telephone #

cc Attending Physician
Next of Kin
Accounts Payable
Preadmission

- -

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this Medicare notice of noncoverage of services from the _____ Hospital at _____ on _____.
(Time) (Date)

I understand that my signature below does not indicate that I agree with the notice only that I have received a copy of the notice.

(Signature of beneficiary or person
acting on behalf of beneficiary)

(Time)

(Date)

cc: MassPRO (via log or upon request)
Attending Physician

PLEASE RETURN IN THE ENCLOSED ENVELOPE

Patient: _____

HIC No.: _____

Telephone Contact Date: 11/2/93

Sent Registered Mail: 11/2/93

Linda Manor Extended Care Facility
349 Haydenville Road
Leeds, MA 01053

Date: 11/13/90

RE:

Name of Beneficiary

To:

HIC Number

10/15/90.

Date of Admission

On 11/13/90, we reviewed your medical information and found that the services furnished no longer qualified as covered under Medicare beginning 11/15/90. The reason is:

Medicare covers medically necessary skilled care needed on a daily basis. You only needed custodial nursing care after 10/14/90. Since you no longer need skilled nursing and do not need skilled rehabilitation on a daily basis we believe your stay beginning 11/15/90 is not covered under Medicare.

This decision has not been made by Medicare. It represents our judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for the services you received before 11/15/90. Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision, you must request that the bill submitted to Medicare include the services we determined to be noncovered. Medicare will notify you of its determination. If you disagree with that determination, you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely,

C. Guernsey

Signature of Administrative Officer

11/13/90.

Date

CC: Physician, Patient Accounting, Medicare File
Letter 6

Confirmation Sheet B

Date: 11/13/90

RE:

Name of Beneficiary

- [] A. I do want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

You are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

ch A or B

If you do not receive a formal Notice of Medicare Determination within 90 days of this request, you should contact:

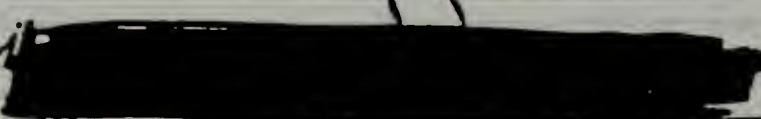
Aetna/Medicare
270 Farmington Avenue
Farmington, CT 06043

- [✓] B. I do not want my bill submitted to the intermediary for a Medicare decision.

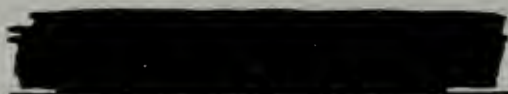
I understand that I do not have Medicare appeal rights if a bill is not submitted.

VERIFICATION OF RECEIPT OF NOTICE

- C. This acknowledges that I received the notice of noncoverage of the services under Medicare on _____.

X 
(Name of Beneficiary or Person acting on Beneficiary's behalf)

- D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on 11/13/90.


(Name of Beneficiary or Representative contacted)

C. Durnestkin
Signature of Administrative Officer

KEEP A COPY OF THIS FOR YOUR RECORDS

37 SH.V

REQUEST FOR RECONSIDERATION OF PART A HEALTH INSURANCE BENEFITS

INSTRUCTIONS. Please type or print firmly. Leave the block empty if you cannot answer it. Take or mail the WHOLE form to your Social Security office which will be glad to help you. Please read the statement on the reverse side of page 2.

1 BENEFICIARY'S NAME

2 HEALTH INSURANCE CLAIM NUMBER

3 REPRESENTATIVE'S NAME IF APPLICABLE

☐ RELATIVE ☐ ATTORNEY ☐ OTHER PERSON

☐ PROVIDER
FILING

4. PLEASE ATTACH A COPY OF THE NOTICE(S) YOU RECEIVED ABOUT YOUR CLAIM TO THIS FORM.

5 THIS CLAIM IS FOR

☐ INPATIENT HOSPITAL
☐ EMERGENCY HOSPITAL

☐ SKILLED NURSING FACILITY (SNF)
☐ HOME HEALTH AGENCY (HHA)

☐ HEALTH MAINTENANCE ORGANIZATION (HMO)

6 NAME AND ADDRESS OF PROVIDER (HOSPITAL, SNF, HHA, HMO)

CITY AND STATE

PROVIDER NUMBER

7 NAME OF INTERMEDIARY

CITY AND STATE

INTERMEDIARY NUMBER

8 DATE OF ADMISSION OR START OF SERVICES

9 DATE(S) OF THE NOTICE(S) YOU RECEIVED

10 I DO NOT AGREE WITH THE DETERMINATION ON MY CLAIM. PLEASE RECONSIDER MY CLAIM BECAUSE

11 YOU MUST DETACH ANY EVIDENCE (if possible) FROM THIS FORM AND SUBMIT IT SEPARATELY TO THE SOCIAL SECURITY OFFICE.

☐ I HAVE ATTACHED THE FOLLOWING EVIDENCE:

☐ I WILL SEND THIS EVIDENCE WITHIN 14 DAYS

☐ I HAVE NO ADDITIONAL EVIDENCE OR OTHER INFORMATION TO SUBMIT WITH MY CLAIM

12 ONLY ONE SIGNATURE IS NEEDED. THIS FORM IS SIGNED BY

☐ BENEFICIARY ☐ REPRESENTATIVE ☐ PROVIDER/REP

SIGN
HERE

13 STREET ADDRESS

CITY, STATE, ZIP CODE

TELEPHONE

DATE

14 IS THIS REQUEST FILED WITHIN 60 DAYS OF THE DATE OF YOUR NOTICE?

☐ YES ☐ NO

IF YOU CHECKED NO, ATTACH AN EXPLANATION OF THE REASON FOR THE DELAY TO THIS FORM

15 If this request is signed by mark (X), TWO WITNESSES who know the person requesting reconsideration must sign in the space provided on the reverse side of this page of the form

DO NOT FILL IN BELOW THIS LINE—FOR SOCIAL SECURITY USE—THANK YOU

16 ADJUTING	<input type="checkbox"/> INTERMEDIARY
	<input type="checkbox"/> HHA OR MEDICARE
	<input type="checkbox"/> BASS OOR

17 SSA (OR OTHER SOCIAL SECURITY OFFICIAL) DATE STAMP

INTERMEDIARY FILE

... HCFA-2649 ...

38 SHINE

REQUEST FOR REVIEW OF PART B MEDICARE CLAIM
Medical Insurance Benefits - Social Security Act

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

1 Carrier's Name and Address

2 Name of Patient

3 Health Insurance Claim Number

4 I do not agree with the determination you made on my claim as described on my Explanation of Medicare

Benefits dated:

5 MY REASONS ARE: (Attach a copy of the Explanation of Medicare Benefits, or describe the service, date of service, and physician's name—NOTE.—If the date on the Notice of Benefits mentioned in item 3 is more than six months ago, include your reason for not making this request earlier.)

6 Describe Illness or Injury:

7 ☐ I have additional evidence to submit. (Attach such evidence to this form.)

☐ I do not have additional evidence.

COMPLETE ALL OF THE INFORMATION REQUESTED. SIGN AND RETURN THE FIRST COPY AND ANY ATTACHMENTS TO THE CARRIER NAMED ABOVE. IF YOU NEED HELP, TAKE THIS AND YOUR NOTICE FROM THE CARRIER TO A SOCIAL SECURITY OFFICE, OR TO THE CARRIER. KEEP THE DUPLICATE COPY OF THIS FORM FOR YOUR RECORDS.

8 SIGNATURE OF EITHER THE CLAIMANT OR HIS REPRESENTATIVE

Representative

Claimant

Address

Address

City, State, and ZIP Code

City, State, and ZIP Code

Telephone Number

Date

Telephone Number

Date

MEDICARE CLAIMS PROCESSING EXERCISE

1. After September 1, 1990, the Medicare provider must file all claims for Medicare Supplement insurance.
T_____F_____
2. For claim purposes, the Medicare beneficiary must tell the provider of certain situations involving subrogation or third party payment by entities other than Medicare. Name three such situations.

3. Railroad retirees have a different company contracted as their Part B carrier. Which company?

4. Medicare clearly explains all hospital payments which it makes to a beneficiary. T_____ F_____.
5. Which form explains Part A benefits used?

6. Which form explains the Part B benefit paid to the beneficiary?
_____.
7. What form does a Medicare recipient need to have before she/he can file a claim with the supplement insurance company?
_____.
8. Name 3 items required by some Medicare supplement companies to file a claim.
 1. _____
 2. _____
 3. _____.
9. The first step to appeal a hospital stay is to contact which organization?
_____.

Which organization provides legal representation for a Medicare appeal?
_____.

AC SHINE

10. The initial appeal for a Part B review goes to what organization?

11. An assigned claim means that

_____. Medicare
sends its payment to _____.

12. An unassigned claim means that _____

The Medicare payment goes to _____.

13. Whether assigned or unassigned, the beneficiary owes 20% of the Medicare approved amount for all Part B services.

T_____ F_____. Explain your answer.

_____.

14. A physician cannot accept assignment if they are a non-participating provider. T_____ F_____

15. A Medicare-certified lab will bill the beneficiary 20% because it is a Part B service. T_____ F_____.

16. Name 4 Part B services provided in the hospital which are not reimbursed by Medicare Part A. (inpatient)

1. _____ 2. _____
3. _____ 4. _____

17. Medicare provides easy access to its changes and regulation and every Medicare beneficiary should therefore know all the facts. T_____ F_____.

19. Anyone who answered the above question "True":

- a. is a Medicare spy
- b. blissfully believes in the Freedom of Information Act.
- c. obviously has not reached age 65 yet.

Explanation of Your Medicare Part B Benefits

Summary of this notice dated February 17, 1994

Total charges:	\$	120.00
Total Medicare approved	\$	52.70
We paid your provider:	\$	0.00
Your total responsibility:	\$	52.70

Your Medicare number is:

Your provider accepted assignment.

Details about this notice (See the back for more information.)

BILL SUBMITTED BY: Kenneth M. M.D. (B23073)
Mailing address: Suite , Centre Street, Boston, MA 02130-3446

Dates	Services and Service Codes	Charge	Medicare Approved	See Note Below
Jan 11, 1994	Claim control number 02-94024-279-470 1 Office/outpatient visit, est (99214)	\$ 120.00	\$ 52.70	a

Notes:

- The approved amount is based on the fee schedule.
- This information is being sent to your private insurer. They will review it to see if additional benefits can be paid. Send any questions regarding your supplemental benefits to them.

Here's an explanation of this notice:

Of the total charges, Medicare approved	\$ 52.70	Your provider agreed to accept this amount. See #4 on b. You have met \$ 52.70 of your \$100.00 deductible for 1994. Medicare pays 80% of this total.
Less the deductible applied	- 52.70	
Approved amount less deductible	\$ 0.00	
Medicare owes	\$ 0.00	
We are paying the provider	\$ 0.00	
Of the approved amount	\$ 52.70	The provider may bill you for this amount.
Less what Medicare owes	- 0.00	
Your total responsibility	\$ 52.70	

IMPORTANT: If you have questions about this notice, call C&S Administrative Services at 1-800-882-1228 or 1-617-741-3300. If you want you can mail your questions to P.O. Box 1000, Hingham, Ma 02044 or visit us at 75 William Terry Dr., Hingham, Ma. You'll need this notice when you call or visit us.

To appeal our decision, you must WRITE to us before August 17, 1994. See #2 on the back.

Important Information You Should Know About Your Medicare Part B Benefits

This part of the notice answers some questions about receiving Medicare payments. If you have other questions, see your copy of *The Medicare Handbook* or call us for more information.

What should I do if I have questions about this notice?

If you have questions about this notice, call, write or visit us and we will tell you the facts that we used to decide what and how much to pay. Turn to the front of this notice; our address and phone number are on the bottom of the page.

Can I appeal how much Medicare paid for these services?

If you do not agree with what Medicare approved for these services, you may appeal our decision. To make sure that we are fair to you, we will not allow the same people who originally processed these services to conduct this review.

However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late (for example, if you had an extended illness which kept you from being able to file on time).

Turn to the front of this notice, the deadline date and our address are on the bottom of the page. It may help your case if you include a note from your doctor or supplier (provider) that tells us what was done and why.

If you want help with your appeal, you can have a friend, lawyer or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

How much does Medicare pay?

The details on the front of this notice explain how much Medicare paid for these services. See your copy of *The Medicare Handbook* for more information about the benefits you are entitled to as a beneficiary in the Medicare Part B program. If you need another copy of the handbook, call or visit your local Social Security Office.

Medicare may make adjustments to your payment. We may reduce the amount we pay for services by a certain percentage (Balanced Budget Law). If your provider accepted assignment, you are not liable to pay the amount of this reduction. We pay interest on some claims not paid within the required time.

All Medicare payments are made on the condition that you will pay Medicare back if benefits are also paid under insurance that is primary to Medicare. Examples of other insurance are employer group health plans, automobile medical, liability, no fault or workers' compensation. Notify us immediately if you have filed or could file a claim with insurance that is primary to Medicare.

4. How can I reduce my medical costs?

Many providers have agreed to be part of Medicare participation program. That means that they will always accept the amount that Medicare approves as their full payment. Write or call us for the name of a participating provider or for a free list of participating providers.

A provider who accepts assignment for covered services can charge you only for the part of the annual deductible you have not met and the copayment which is 20 percent of the approved amount.

If you are treated by one of these doctors, you can save money. See *The Medicare Handbook* for more information about how you can reduce your medical costs.

Generally a doctor who has not accepted assignment may not charge more than 120 percent of the Medicare approved amount for services provided in 1992, or more than 115 percent for services provided in 1993 or later. This is known as the limiting charge. Contact us if assignment was not accepted, and you think your doctor charged more than the limiting charge.

Some States have laws that could further reduce your medical costs. Please see the Medicare Handbook published in 1993 or later for more information.

5. How can I use this notice?

You can use this notice to:

- Contact us immediately if you think Medicare paid for a service you did not receive;
- Show your provider how much of your deductible you have met;
- Claim benefits with another insurance company. If you send this notice to them, make a copy of it for your records.

Keep this notice for your records.



MEDEX CLAIM SUMMARY

This notice explains how we processed your claims; It is not a bill. Please look this over carefully. On the back, we've explained what you should do if you have any questions or disagree with how we processed your claims. Please keep this for your tax and medical records.

PROVIDER/ SERVICES	DATES OF SERVICE	UNITS	AMOUNT CHARGED	MEDICARE ALLOWED	MEDEX ALLOWED	YOUR CO-INS	BENEFITS	YOUR BALANCE	MS CC
MEDEX CLAIM #: 30940281552900 MEDICARE CLAIM #: 0294024279470									
PROVIDER: K M PARISER MD									
OFFICE VISITS	01/11/94-01/11/94	1	120.00	52.70	0.00	0.00	0.00	52.70	A
TOTAL -----			120.00	52.70	0.00	0.00	0.00	52.70	
A-WE CANNOT PAY THIS SERVICE FOR ONE OF THE FOLLOWING REASONS: 1)MEDICARE PAID THIS SERVICE IN FULL. 2)MEDICARE DID NOT ALLOW THIS SERVICE. 3)THIS SERVICE IS NOT COVERED UNDER YOUR MEDEX CONTRACT. (P028)									
GRAND TOTAL -----			120.00	52.70	0.00	0.00	0.00	52.70	

ID NUMBER/
HIC NUMBER

MEMBER NAME

DATE

XXA008

02/11/94

112 54111

IF YOU HAVE A QUESTION ABOUT YOUR CLAIM, YOU MAY CALL OR WRITE:

TELEPHONE:

Metropolitan Boston: (617) 956-3790

Toll Free: 1-800-258-2226

Telecommunication Device

for the Deaf Service Number: (617) 956-3801

When writing, please use this form. Fill in only the spaces that apply. You may also use this space to correct our records. Thank you.

Identification Number: _____ **XXA008**

Subscriber Name:

Address:

Your Telephone Number: () _____

After we have reviewed your claim, you may appeal our decision if you feel that you have been improperly denied all or part of your benefits.



A Massachusetts Guide to Medicare & Medicare HMO APPEALS

*----what you need to know about
Hospital and Medical Appeals*

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How to Appeal a Medicare Claim

Introduction

There are separate appeals processes for Medicare Part A services, Medicare Part B services, and Medicare HMOs.

The appeal processes take time and perseverance in order to succeed. However, it can be worthwhile to appeal a denial when a Medicare beneficiary believes the services being denied are Medicare-covered services to which they are entitled.

After you have read this material, you will be able to help Medicare beneficiaries identify situations where Medicare coverage may be wrongfully denied. And, just as important, you will be able to explain what steps a beneficiary must take to initiate an appeal within the time guidelines of the fee-for-service or the Medicare HMO appeal systems.

Most Medicare appeals involve issues relating to:

- whether or not a service is medically necessary or appropriate for the treatment or diagnosis of an illness or injury.
- how much Medicare will pay towards a claim.
- whether or not a facility or medical provider should provide a certain medical service to a patient (level of care questions).
- the meaning of “urgent” versus “emergency” care in a Medicare Managed Care Plan (HMO).
- the quality of care they receive from medical staff and in medical settings.

You will learn what actions can be taken when one of these types of Medicare appeals occurs in the course of your SHINE counseling.

In order for any system of benefits to be fairly administered, the rights and responsibilities of the parties within the system must be clearly written so the parties can know what is their due. In the Medicare system, the Medicare Handbook describes the Medicare-covered benefits offered under Part A and Part B of Medicare. If the Handbook is absolutely clear about the types of services Medicare does not cover, then the Medicare beneficiary is presumed to know and understand that Medicare won't pay for those services. In this case, a provider is not required to notify the beneficiary because the rules are clearly printed in the Handbook; for example, a TV in one's hospital room is never paid for by Medicare.

However, it is not possible for the Medicare Handbook to clearly describe every medical service as covered or non-covered under all circumstances. Some medical procedures are only covered when certain additional factors are present. For example, foot care may or may not be covered, depending upon the underlying disease that causes a risk to the health of the foot. Consider ambulance service; it will not be reimbursed if the ambulance was used as transportation to a doctor's office for a routine physical but it will be reimbursed if used to get to a hospital for emergency treatment.

As a last point of introduction, it is important to understand there are two types of notices used in the Medicare system: those that are **not official Medicare determinations** and those that are **official Medicare determinations**.

The following are form letters or oral exchanges between a medical provider and a Medicare beneficiary; they are **not official Medicare notices**:

- Notices of Non-Coverage (NNC)
[a SNF may use a "Skilled Nursing Facility Termination Notice"]
- verbal discussions with providers in which Medicare services are terminated or refused.

Official Medicare determinations are issued by the Medicare intermediary, MassPRO, or the Medicare carrier and include the following:

- Notice of Initial Determination
- Notice of Utilization
- Explanation of Medicare Benefits (EOMBs)
- Reconsideration Determination

APPEALS FOR MEDICARE PART A SERVICES

Skilled nursing facility services and home health benefits in the fee-for-service system.

CASE 1: *You have been receiving medical services as a patient in a skilled nursing facility, but have been told by the facility staff that Medicare won't cover your stay after a few more days. What can you do?*

CASE 2: *Or, you want to engage the services of a home health company, but they do not believe you meet one of Medicare's guidelines for home health care. What can you do?*

STEP 1 -

GET A WRITTEN NOTICE OF NON-COVERAGE (NNC)

A Part A provider should give you a written NNC to explain the services you seek will not be paid for by Medicare. If they have spoken to you about "no coverage for benefits", ask them to give you a written NNC.

STEP 2 -

ASK THE PROVIDER TO REQUEST AN OFFICIAL MEDICARE DETERMINATION

If you so request, the provider must submit a "demand bill" (also referred to as a "no-payment bill") to the Medicare intermediary on your behalf. A Medicare beneficiary always has the right to have a claim submitted to Medicare. Therefore, when a provider decides that a service is not covered, a bill at the request of the beneficiary can be submitted. The beneficiary must ask the Part A provider to get the official Medicare determination in order to develop the right to request further appeals. *When beneficiaries are unaware of their rights, they wrongly assume the provider's NNC is an official Medicare determination when, in fact, it is not an official determination by Medicare!*

STEP 3 -

RECEIVE THE OFFICIAL MEDICARE DETERMINATION IN THE FORM OF A NOTICE OF UTILIZATION

Medicare sends you a Notice of Utilization which states its ruling. If you do not receive this official determination within thirty days, then contact the local intermediary. If they rule in your favor, then you get the services requested paid for by Medicare. However, if you still disagree with the ruling, ask for a Reconsideration Determination.

STEP 4 -

REQUEST A RECONSIDERATION DETERMINATION

If you still disagree with the ruling in the Notice of Utilization, ask for a Reconsideration Determination by writing a letter to the intermediary. Its address is on the recent Notice of Utilization. Include in your written request a copy of the NNC and Notice of Utilization. You have 60 days from the date you received the Notice of Utilization to make this request.

STEPS 5 AND BEYOND -

INTERMEDIARY SENDS YOU A RECONSIDERATION DETERMINATION

The intermediary will assign someone new to reconsider your case and issue a determination. If they confirm your belief that Medicare services should be provided to you, then you have won. However, if they continue to rule against you, read the instructions on the reconsideration determination to learn about the next appeal step (a hearing before an Administrative Law Judge).

APPEALS FOR MEDICARE PART A SERVICES

Hospital pre-admission denial

CASE 3: *You want to have your surgery performed at the local acute care hospital, but the hospital has informed you that you will not be admitted as an inpatient for this procedure. What can you do?*

INTRODUCTION

If a hospital decides not to admit you to the hospital, it must give you its decision in writing. However, this decision is **not an official Medicare determination**. In order to get an official Medicare determination, follow these steps:

STEP 1 -

ASK MASSPRO TO REVIEW THE HOSPITAL'S DECISION

You must ask MassPRO to review the hospital's decision. You can ask for an immediate review if you contact MassPRO within three days of the date you received the hospital's decision. You can contact MassPRO by telephone at 1-800-252-5533 or in writing at MassPRO, 235 Wyman Street, Waltham, MA 02154-1231. Otherwise, you have 30 days to ask MassPRO to make a review. If the hospital had already consulted with MassPRO while making its decision, then you are actually asking MassPRO to reconsider the pre-admission denial.

STEP 2 -

RECEIVE MASSPRO'S DETERMINATION

MassPRO will review the hospital's decision and send out an official Medicare determination. If MassPRO agrees with you and decides Medicare should pay for your stay in the hospital, then hospital will be expected to admit you. If MassPRO agrees with the hospital, the reconsideration determination will explain your rights and the next steps to take to continue the appeal.

APPEALS FOR MEDICARE PART A SERVICES

Inpatient hospital Notice of Non-Coverage

CASE 4: *You have been in the hospital for ten days because you have a broken hip. The hospital issues a Notice of Non-Coverage to you stating that in three days time you will be discharged home. You think the discharge is premature. What can you do?*

INTRODUCTION

For Medicare beneficiaries in a Medicare HMO or in the fee-for-service system, the appeal steps are exactly the same when requesting an **expedited review** for premature hospital discharges.

STEP 1 -

REQUEST TO RECEIVE THE NOTICE OF NON-COVERAGE IN WRITING

The hospital must give you a written notice which explains their belief Medicare will no longer pay for your stay and includes the phone number of the Massachusetts Peer Review Organization (MassPRO).

STEP 2 -

ASK MASSPRO TO REVIEW THE HOSPITAL'S DECISION

You must ask MassPRO to review the hospital's decision. You can ask for an immediate review if you contact MassPRO by **noon of the next business day** (Saturdays and Sundays not included) after the date you received the Notice of Non-Coverage.

If you do not request an expedited review, you will have 30 days to ask MassPRO to make a review. If the hospital had already consulted with MassPRO while making its decision, then you are actually asking MassPRO to reconsider the decision to discharge you from your current Medicare-covered stay in the hospital. You can contact MassPRO by telephone at 1-800-252-5533 or in writing at MassPRO, 235 Wyman Street, Waltham, MA 02154-1231.

If you did not request an expedited review **and** are enrolled in a Medicare HMO, you will have 60 days from the date on the Notice of Non-Coverage to ask the HMO to make a review. If the HMO does not rule in your favor, they will automatically send the appeal on to the Network Design Group.

STEP 3 -

RECEIVE MASSPRO'S DETERMINATION

MassPRO will review the discharge decision and send out an official Medicare determination (if they are reconsidering their previous decision, then it will be a reconsideration determination). If MassPRO agrees with you and decides Medicare should pay for your stay in the hospital, then the hospital will be expected to retain you as an inpatient for the time being. If MassPRO agrees with the hospital, then the determination will also explain your rights and the next steps to take to continue the appeal.

APPEALS FOR MEDICARE PART B SERVICES

Doctor's services, outpatient hospital care, diagnostic services, durable medical equipment and ambulance services.

Typical Case: EOMBs are often reviewed when coverage is denied, the amounts allowed seem out of line, when claims are denied for insufficient information or omitted facts, or when the medical necessity of certain procedures has not been fully demonstrated when the claim form was submitted by the Part B provider.

STEP 1 - REQUEST A REVIEW FROM THE CARRIER BY MAIL OR BY TELEPHONE

On the EOMB attach a note saying "Please review", sign it, and send it back to the carrier. The carrier's name and address are on the form. If appropriate, a letter from the doctor explaining the medical necessity for the procedure can also be included. You have six months to send in your request for a review.

You may also use the telephone to conduct the review. Between 8 AM and 4 PM, Monday through Friday, you may call the carrier for Massachusetts, known as C & S Administrative Services, at 1-800-294-2351 to request a review over the telephone. You must still request the review within six months of the date the EOMB was issued.

When you call, be prepared to tell the carrier the following facts:

- your full name
- current address
- your Medicare health insurance claim (HIC) number
- the 13-digit claim control number on the claim you want reviewed (this is on the EOMB)
- and the date of service.

In most cases, the carrier can inform you of its official determination of the review during the telephone call. You will also receive a formal letter or an adjusted EOMB. Follow the instructions on the review determination if a further appeal is necessary. The next step is a fair hearing before a carrier hearing officer.

For appeals regarding durable medical equipment, the carrier for Massachusetts is:

MetraHealth
DMERC
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Tel: 1-800-842-2052

APPEALS IN MEDICARE HMOs

Typical case: You have been receiving home health services three times a week with Medicare fee-for-service. You decide to enroll in a Medicare HMO and three weeks later you are informed by the Medicare HMO that they will not pay for any further home health services. You feel you still need assistance and you have contacted your primary care physician about your concerns.

INTRODUCTION

Medicare beneficiaries in Medicare HMO plans have similar appeal steps for questioning decisions made by HMO staff as to the medical necessity of services and the appropriateness of certain

settings for receiving medical care. If an HMO refuses to supply Medicare-covered services you have requested, then they must give you the denial in writing.

STEP 1 -

GET THE DECISION IN WRITING

Under the law, the HMO must give you a written denial if the treating physician says you cannot have a particular service. Tell the physician **"I want your decision in writing"**. This denial is called a **"Notice of Initial Determination"**. Along with this notice, the HMO is required to give you an explanation of your appeal rights.

STEP 2 -

ASK FOR A RECONSIDERATION IN WRITING

Send your request for a reconsideration to the HMO within 60 days of the date you received the Notice of Initial Determination. In your letter requesting a reconsideration, tell the HMO that you believe the plan has an obligation to provide the service because you believe it is a Medicare-covered service. Also, include a copy of the written Notice of Initial Determination given to you by the physician or the HMO.

STEP 3 -

RECEIVE THE RECONSIDERATION DETERMINATION

Your HMO has 60 days to reconsider its initial determination to deny the services or payment for services you believe they should provide. If the HMO agrees with you upon appeal, then they shall provide the service or pay for the care you received. However, if the HMO denies your request on appeal, then it must automatically submit your case for further review to an independent group called the Network Design Group (NDG).

STEP 4 -

AWAIT THE DETERMINATION OF THE NETWORK DESIGN GROUP (NDG)

The NDG can take up to five months to issue its determination. If you lose at this stage, the determination shall contain instructions on how to request a hearing before the Administrative Law Judge.

DIRECTORY

INTERMEDIARIES - Part A Claims

Aetna Life Insurance Company 203-636-5666
151 Farmington Ave.
Hartford, CT 06156

Associated Hospital Service of Maine 207-822-8484
2 Gannet Drive
South Portland, Maine 04106
Processes claims for: *hospital, SNF, home health, hospice*

CARRIERS - Part B Claims

C & S Administrative Services 800-882-1228
P.O. Box 1000
Hingham, MA 02044-9191

MetraHealth (Travelers Insurance Co.) 800-842-2052
Durable Medical Equipment Regional Carrier
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

MetraHealth (Travelers Insurance Co.) 800-833-4455
Railroad Medicare Claim Service Center
P.O. Box 10066
Augusta, GA 30999-0001

MEDICARE FRAUD & ABUSE HOTLINE

Department of Health & Human Services 800-368-5779
Concerns about abuse of services or billings to Medicare

Office of the Inspector General (Boston) 617-565-2664

C & S Administrative Services (Part B Claims) 800-882-1228

PEER REVIEW ORGANIZATION (PRO)

Massachusetts Peer Review Organization (MassPRO)

235 Wyman Street
Waltham, MA 02154-1231

800-252-5533
617-890-0011

MEDICARE ADVOCACY PROJECT

Serving Essex, Middlesex, Norfolk and Suffolk counties.

Greater Boston Legal Services

197 Friend Street
Boston, MA 02114

800-323-3205
617-371-1234

Serving Barnstable, Dukes, Nantucket and Plymouth counties.

Legal Services for Cape Cod and Islands

460 West Main Street
Hyannis, MA 02601

800-742-4107
508-775-7020

Serving Essex and Middlesex counties.

Merrimack Valley Legal Services

11 Lawrence Street, Suite 324
Lawrence, MA 01840

800-427-2521
508-687-1177

Serving Bristol and Plymouth counties.

Southeastern Massachusetts Legal Assistance Corp.

21 South Sixth Street
New Bedford, MA 02740

800-244-9023
508-996-8576

Serving Franklin, Hampden, Berkshire and Hampshire counties.

Western Massachusetts Legal Services

145 State Street
Springfield, MA 01103

413-781-7814

Serving Worcester county.

Legal Assistance Corp. of Central Massachusetts

405 Main Street, 4th Floor
Worcester, MA 01608

800-649-3718
508-752-3718

MASSACHUSETTS STANDARD MEDIGAP PLANS
FOR PEOPLE WITH MEDICARE

OBJECTIVES OF THIS SECTION:

Introduce you to the standard Medigap policies available in Massachusetts;

Help you learn about the Federal and State laws and regulations regarding Medicare Supplement Insurance policies;

Explain the use of tools like Medicare Supplement Outlines of Coverage; and comparison forms for analyzing coverage offered by different policies.

WHAT YOU NEED TO KNOW:

What Medigap policies are available in Massachusetts;

The benefits and limitations of the standard Medigap plans;

Eligibility and enrollment periods for standard Medigap plans;

How to compare Medigap policies; and

How to use outlines of coverage to assist clients.

DEFINITIONS OF SOME MEDICARE AND OTHER HEALTH INSURANCE TERMS

Actual charge: The amount a physician or supplier actually bills for a particular medical service or supply.

Approved Amount: The amount Medicare determines to be reasonable for a service that is covered under Part B of Medicare. It may be less than the actual charge. For physician services the approved amount is taken from a national fee schedule that assigns a dollar value to all physician services covered by Medicare.

Assignment: An arrangement whereby a physician or medical supplier agrees to accept the Medicare-approved amount as the total charge for services and supplies covered under Part B. Medicare usually pays 80% of the approved amount directly to the provider after the beneficiary meets the annual Part B deductible of \$100. The Beneficiary pays 20%.

"Ban on Balance Billing": Under Massachusetts General Laws Chapter 112, section 2, no physician who agrees to treat a Medicare beneficiary may charge to or collect from that beneficiary any amount in excess of the reasonable charge for that service as determined by the United States Secretary of Health and Human Services for Medicare covered services. This prohibition is commonly referred to as the **"ban on balance billing"**.

A physician is allowed to charge you or collect from your insurer a copayment or co-insurance for Medicare-covered services. However, if your physician charges you or attempts to collect from you an amount which together with your copayment or co-insurance is greater than the Medicare approved amount, please contact the Board of Registration in Medicine at (617) 727-3086.

Coinsurance: The portion or percentage of Medicare approved amounts for covered services that a beneficiary is responsible for paying.

Deductible: The amount of expense a beneficiary must first incur before Medicare begins payment for covered services.

Eligible Person: Any person who is eligible for Medicare Parts A and B and is enrolled in Medicare Part B regardless of age; however, Issuers and HMOs are not required to provide coverage to a person who is under age 65 and is eligible for Medicare due solely to end-stage renal disease; provided further, nothing prevents an Issuer or HMO from providing coverage to persons with end-stage renal disease.

Evidence of Coverage: Any contract or agreement or certificate issued to a member of an HMO.

Excess Charge: The difference between the Medicare-approved amount for a service or supply and the actual charge, if the actual charge is more than the approved amount.

Individual Policy: Is a contract between one person, the "policy holder", and an insurance company. An individual policy may cover an entire family, and all of the family members would be insured.

Initially Eligible for Coverage: a date when an eligible person

- a. first enrolled for benefits under Medicare Part B, or
- b. lost employer-sponsored health coverage due to termination of employment, employer bankruptcy, or because of the discontinuance of employer-sponsored health coverage offered to similarly situated employees, or
- c. moved out of the HMO service area, or
- d. became a resident of Massachusetts.

Insurance Contract: Is the master copy of a policy which is submitted to the State Division of Insurance for approval and sale. It is assigned a form number which is listed in the bottom left corner of the cover. This number should be used when seeking information from the State Division of Insurance.

Insurance Policy: Is the individual copy of the master contract which contains a policy number assigned only to the subscriber. That policy number should be used when contacting the insurance company for information.

Issuer: Any company which sells or renews Medicare Supplement Insurance Policies; Issuer shall not include Health Maintenance Organizations.

Late Enrollee: An eligible person who has submitted an application for a Medicare Supplement Insurance Policy after the six month period beginning with first month the eligible person:

- a. first enrolled for benefits under Medicare Part B, or
- b. lost employer-sponsored health coverage due to termination of employment, employer bankruptcy, or because of the discontinuance of employer-sponsored health coverage offered to similarly situated employees, or
- c. moved out of the HMO service area, or
- d. became a resident of Massachusetts.

Limiting Charge: The maximum amount a physician may charge a Medicare beneficiary for a covered service if the physician does not accept assignment of the Medicare claim. The limit is 15% more than the fee schedule amount for nonparticipating physicians. Limiting charge information appears on Medicare's **Explanation of Medicare Benefits (EOMB) form**.

Medicare Hospital Insurance: This is Part A of Medicare. It helps pay for medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice and home health care.

Medicare Medical Insurance: This is Part B of Medicare. This part helps pay for medically necessary physician services and many other medical services and supplies not covered by Part A.

Participating Physician and Supplier: A physician or supplier who agrees to accept assignment on all Medicare claims.

A group policy is a contract between the insurance company and an organization, association, employer or other entity.

- a. The organization has a "**master contract**" and is the "**policy holder**".
- b. The organization enrolls members or employees, who become "**certificate holders**".
- c. The price of group coverage is often lower than similar coverage in an individual contract.

Massachusetts does not regulate employer or union group policies. They do regulate association and organization group policy. Example AARP is an association, and their group policies are regulated by the state.

Pre-existing condition: Any medical condition for which an individual receives treatment, advice or medication prior to obtaining insurance coverage.

INTRODUCTION

There are aspects of the Medicare program some people find complex and confusing. A person may be uncertain about what Medicare covers and doesn't cover and how much it pays toward your medical expenses. They may not realize that when Medicare was established it was to help older adults pay for some of their health care costs. The Medicare beneficiary would share the costs of coverage including deductibles and copayments on both the Hospital (Part A) and Medical (Part B) portions of its costs.

Some medical costs, such as outpatient prescription drugs, routine care, physical exams and excess charges were excluded entirely from the Medicare program.

Medicare Benefit Charts

Charts on the next two pages show Medicare benefits only. The "You Pay" column itemizes expenses a beneficiary must pay out of their own pocket or through the purchase of some type of private insurance as described in this chapter.

MEDICARE PART A: HOSPITAL INSURANCE-COVERED SERVICES FOR 1997

Services	Benefit	Medicare Pays	You Pay
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. (Medicare payments based on benefit periods)	First 60 days	All but \$760	\$760
	61st to 90th day	All but \$190/day	\$190/day
	91st to 150th day*	All but \$390/day	\$380/day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY CARE You must have been in a hospital for at least 3 days and enter a Medicare -approved facility generally within 30 days after hospital discharge.** (Medicare payments based on benefit periods.)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but \$95.00 a day	\$95.00/day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermittent care for as long as you meet Medicare conditions.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE pain relief, symptom management and support services for the terminally ill.	If you elect hospice option and as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Unlimited if medically necessary	All but first three pints per calendar year.	For first 3 pints.***
1997 Part A monthly premium: None for most beneficiaries. \$311 a month if you have less than 30 quarters. \$187 a month if you have 30-39 quarters.			

* This 60-reserve-day benefit may be used only once in a lifetime.

** Neither Medicare nor private Medigap insurance will pay for most nursing home care.

*** To the extent the blood deductible is met under Part B of Medicare during the calendar year, it does not have to be met under Part A.

**MEDICARE (PART B): MEDICAL INSURANCE
COVERED SERVICES FOR 1997**

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSES Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, ambulance, diagnostic tests, and more.	Medicare pays for medical services in or out of the hospital.	80% of approved amount, after \$100 deductible.	\$100 deductible* plus 20% of approved amount and limited charges above the approved amount.
CLINICAL LABORATORY SERVICES Blood test, urinalyses, and more.	Unlimited if medically necessary.	100% of approved amount.	Nothing for services.
HOME HEALTH CARE Medically necessary and skilled care.	Part-time or intermittent skilled care for as long as you meet conditions for benefits.	100% of approved amount; 80% of approved amount for durable equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT Services for the diagnosis or treatment of illness or injury.	Unlimited if medically necessary.	Medicare payment to hospital based on hospital cost.	\$100 deductible, plus 20% of billed charges.
BLOOD	Unlimited if medically necessary.	80% of approved amount (after \$100 deductible and starting with 4th pint.)	First 3 pints plus 20% of approved amount for additional pints (after \$100 deductible)**
1997 Part B monthly premium: \$43.80 (Premium may be higher if you enroll late.)			

* Once you have had \$100 of expenses for covered services in 1997, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

** To the extent the blood deductible is met under Part A of Medicare during the calendar year, it does not have to be met under Part B.

The following are gaps in Medicare Coverage, which a beneficiary is responsible for. They include:

1. Medicare Inpatient Hospital Coverage:

- a. No coverage beyond 90 days in any benefit period unless you have **lifetime reserve** days available and use them.
- b. No coverage for private hospital room or private duty nurse.
- c. Personal convenience items.
- d. Care that is not medically necessary or for non-emergency care in a hospital not certified by Medicare.
- e. Care outside the U.S. and its territories, except under limited circumstances in Canada or Mexico.

2. Medicare Skilled Nursing Facility (SNF) Coverage:

- a. No coverage beyond 100 days in a benefit period.
- b. No coverage for care in a SNF not certified by Medicare, or for just custodial care in a Medicare-certified SNF.

3. Medicare Home Health Coverage:

- a. Full-time nursing care.
- b. Drugs or meals delivered to home.
- c. Homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

4. Medicare Hospice Coverage:

- a. Limited charges for inpatient respite care and outpatient drugs.
- b. Deductibles and coinsurance amounts when regular Medicare benefits are used for treatment of a condition other than the terminal illness.

5. Medical Services:

- a. Legally permissible charges in excess of the Medicare-approved amount for unassigned claims from some Part B providers.
- b. Most self-administrable prescription drugs and immunizations, except for pneumococcal, influenza and hepatitis B vaccinations.
- c. Routine physicals and other screening services, except for mammogram every other year and Pap smears every third year.
- d. Hearing aids or routine hearing loss examinations.
- e. Most services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.
- f. Dental care or dentures.
- g. Acupuncture treatment.
- h. Care received outside the United States and its territories, except under limited circumstances in Canada and Mexico.
- i. Routine foot care, except when a medical condition affecting the lower limbs (such as diabetes) requires care by a medical professional.

- j. Services of a neuropath, Christian Science practitioners, immediate relatives, or charges imposed by members of your household.
- k. Routine eye examinations or eyeglasses, except prosthetic lenses, if needed after cataract surgery.

MEDIGAP BASICS

Medicare Supplement Insurance, also known as Medigap Insurance, is a special kind of health insurance coverage **available only to people who are eligible for Medicare Parts A and B and enrolled in Medicare Part B.** It was developed to provide extra protection beyond Medicare by filling some of the gaps in Medicare coverage. Under state and federal law, Medicare (Medigap) Supplement Insurance is defined as an individual or group policy designed to supplement Medicare benefits. The definition does not include all insurance products that may help you cover out-of-pocket costs.

Medigap is sold by private insurance companies, not by the federal government.

Employer-sponsored retiree plans, including those that convert to a policy that supplements Medicare when a retiree turns 65, or those with standard major medical benefits supplement Medicare, but they are not considered actual Medigap policies. Also, limited benefit plans such as hospital indemnity insurance, do not qualify as Medigap policies. They are not required to provide the same benefits the three standard Medigap plans must provide.

All Medigap plans coordinate benefits with Medicare. This **"coordination of benefits"** means that a Medigap policy will generally pay only when Medicare approves payment of a health care expense. However, some Medigap policies will pay for outpatient prescription drugs, skilled nursing facility care and medical services received outside of the United States, regardless of Medicare's approval.

Medigap insurance does not coordinate benefits with any other insurance, nor with other supplements. Consequently, a Medigap policy will pay for a service or supply, even when you have received payment from another Medigap or health insurance policy.

There is also a variety of alternatives to private insurance such as the Medicaid program, the Qualified Medicare Beneficiary Program (QMB), the Specified Low-income Medicare Beneficiary Program (SLMB), and also Federally Qualified Health Centers (FQHCs). These are discussed fully in the Public Benefits chapter.

MEDIGAP REFORMS

Many persons were confused about Medigap insurance. They were overwhelmed by the many policies, terms and conditions. There were sales abuses and many people had duplicate coverage.

In 1990, the 101st Congress passed strong Federal legislation to rectify these problems. It was enacted under the Omnibus Budget Reconciliation Act of 1990 and it is referred to as "**OBRA '90**" or the "**Medigap Reform Law**". The legislation was enacted to establish uniform requirements to govern Medicare Supplement Insurance in every state. Previously, each individual state regulated Medigap insurance differently.

It is expected that these reforms will encourage increased price competition among insurance companies, decrease confusion and provide greater availability of clear, unbiased information for those wishing to make sense of Medigap insurance.

1. Standardized Medigap Policies:

Every state, except Massachusetts, Wisconsin and Minnesota, was required to adopt the 10 standard benefit packages and label them plans A-J. Every company must use the same letter labels so that no matter which company you buy from, its "Plan C" will be identical to every other company's "Plan C". However, the companies' premium will be unique. On the next page is a chart depicting the benefits for each of the ten federally-required Medigap plans.

Chart of the Ten Standard Medicare Supplement Plans

Medicare supplement insurance can be sold in only 10 standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).

Blood: First 3 pints of blood each year.

A	B	C	D	E	F	G	H	I	J
Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drug Benefit (\$1,250 Limit)	Basic Drug Benefit (\$1,250 Limit)	Extended Drug Benefit (\$3,000 Limit)
				Preventive Care					Preventive Care

When the Federal government enacted the Medigap Reform Law, Massachusetts already had an established Medigap regulatory program. Therefore, Massachusetts received a waiver which allowed it to continue with its current system. Massachusetts added additional sales practice standards required under the Medigap Reform Law.

Instead of the ten national standard plans, from 1992 through 1994 Massachusetts had six standard plans available for sale to Massachusetts residents.

In 1995, Massachusetts passed a new Medigap Reform Law effecting all Medigap policies and HMO plans with a Medicare contract. The new law allows the sale of only three standard plans. Medigap plans that were available in Massachusetts in 1992-1994 are no longer available to new enrollees; however, current members may remain in those plans.

As of 1/1/95, Medicare beneficiaries can choose from the three policy formats and find that each has precisely defined benefits. These policies are labeled **Core, Supplement One and Supplement Two**. The Core plan is the most basic and Supplement Two the most comprehensive. Each insurer offering Supplement Two will offer the same menu of benefits as any other insurer offering Supplement Two. So consumers can now compare Supplement Two prices and services from all insurers offering that policy. In Massachusetts, Medigap insurers are required to sell the Core Plan and the Supplement Two.

2. Basic Benefits: All Plans

All Medigap policies must include certain "**Basic Benefits**". These comprise the minimum package of benefits allowed by law to be sold as a Medigap policy. All standardized Medigap policies, Core through Two, must contain these basic benefits.

- a. Part A daily co-payment of \$190 per day in 1997 for hospital care days 61 through 90
- b. Part A daily co-payment of \$380 per day in 1997 for hospital care days 91 through 150
- c. 100% of your Medicare Part A eligible hospital expenses if you use up your lifetime reserve days beyond day 150 of a hospital stay to a lifetime maximum total of 365 additional hospital days during your lifetime.
- d. Part B 20% co-payments for Medicare Part B eligible expenses, after the \$100 deductible is met.
- e. Cost of the first three pints of blood.
- f. Additional 60 days of coverage per calendar year in licensed mental health hospital.

3. Additional Benefits: Supplements One and Two

All standardized Medigap policies must include the "**Basic Benefits**" shown in the above Core plan. Supplement One and Supplement Two must include the following benefits.

- a. **The Part A deductible benefit:** the policy pays the Part A hospital deductible of \$760 in 1997, for each benefit period. That benefit period ends after you have been out of the hospital for 60 consecutive days or more. It is possible

to be responsible for more than one Part A deductible period in a single year. **(Plans One and Two)**

- b. **Skilled nursing facility co-payment benefit for days 21 through 100:** If you qualify for Medicare coverage in a skilled nursing facility, a policy with this benefit will pay the co-payment for days 21-100, \$95.00 per day in 1997. Remember this benefit is limited. A Medigap with this benefit will only pay when skilled nursing facility care is approved by Medicare. Custodial care is **not** covered. **(Plans One and Two)**
- c. **Part B deductible benefit:** the policy that includes this benefit pays the Part B deductible, the first \$100 of Medicare Part B approved medical charges each year. **(Plans One and Two)**
- d. **Foreign travel benefit:** policies that include this benefit pay for medical services received in a foreign country. The plan must cover all the benefits that would be covered by Medicare and the Medigap policy in the United States. **(Plans One and Two)**

4. Additional Benefits: Supplement Two Only

Outpatient prescription drug benefit: with this benefit, you will pay a drug deductible of \$35 per quarter. The policy will then cover 100% of the costs for generic drugs and 80% of the costs for brand name drugs. **There is no monetary limit on the amount for this benefit. (Plan Two only)**

Three Standard Medigap Plans Sold in Massachusetts - 1996

Basic Benefits Included In All Plans	Core	Supplement 1	Supplement 2
Hospitalization Part A Copayments for: Days 61 - 90: \$184/day Days 91-150: \$368/day 365 Additional Lifetime Hospital days - Paid in full	X X X	X X X	X X X
Part B Coinsurance - 20% of the approved amount in most cases, or applicable coinsurance Parts A and B Blood - first 3 pints	X X	X X	X X
Additional Benefits	Core	Supplement 1	Supplement 2
Part A Deductible for Days 1 - 60 - \$736 per benefit period		X	X
Skilled Nursing Facility Coinsurance - for days 21-100 - \$92 per day		X	X
Part B Annual Deductible - \$100.00		X	X
Foreign Travel - for Medicare-covered services needed while traveling abroad.		X	X
Inpatient Days for Mental Health Hospitals- in addition to Medicare's coverage of 190 lifetime days and less any days previously covered by plan in same benefit period	60 days per calendar year	120 days per benefit period	120 days per benefit period
Outpatient Prescription Drugs ** from Retail Pharmacies after a \$35 calendar quarterly deductible: 100% of cost for generic drugs 80% of cost for brand-name drugs			X
State-Mandated Benefits - Annual Pap Smear Tests Mammogram not covered by Medicare (in off-year) Check your policy for other state-mandated benefits	X	X	X

**** Drugs as defined include insulin, as well as the needles, syringes, pumps and pump supplies necessary for the administration of insulin and blood sugar level testing equipment and supplies for use at home; drugs provided by home infusion therapy provider; and drugs used on an off-label basis for the treatment of cancer or HIV/AIDS and the medically necessary services associated with the administration of such drugs.**

5. Consumer Protection:

The federal law reforming Medicare Supplement Insurance included important consumer protections to resolve many of the problems older adults faced when shopping for, purchasing and using this type of insurance. **Massachusetts Medigap Reform Law has mandated even more extensive consumer protections.**

6. Regulation of individual and group policies:

States must regulate both individual (non-group) and certain group Medigap policies. All individual and association or organization group Medicare Supplement policies **must** be filed with and approved by the state Department of Insurance (the Massachusetts Division of Insurance).

To make sure the policies meet the state's legal requirements, the Division's examiners look at:

- a. Policy Forms
- b. Advertisements and solicitation materials
- c. Rates

An Individual Policy is a contract between one person, the "**policy holder**", and an insurance company. An individual policy may cover an entire family, and all of the family members would be insured.

A Medigap group policy is a contract between the insurance company and an organization (for example), an association other than an employer or union.

- a. The organization has a "**master contract**" and is the "**policy holder**".
- b. The organization enrolls members or employees, who become "**certificate holders**".
- c. The price of group coverage is often lower than similar coverage in an individual contract.

1. Open Enrollment Period: Federal Law

Older adults who became eligible for Medicare may already have an illness or injury. Insurance companies call that illness or injury a **pre-existing condition**. In the past, insurers were able to refuse to sell someone a Medigap policy if they had a pre-existing condition. The federal Medigap Reform Law mandates all persons will be able to buy any Medigap policy sold during the first six months of their Medicare Part B enrollment. This six month period is called the "**open enrollment period**".

It begins at age 65 or older when you first enroll in Medicare Part B,

Medicare Part B Effective Date	2nd Month	3rd Month	4th Month	5th Month	6th Month
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Open Enrollment Rules:

- a. Must be at least 65 years old
- b. **Begins:** The date you **First** enroll in Medicare Part B (when coverage takes effect);
- c. **Ends:** 6 months later
- d. **For persons who work past 65 and delay joining Part B until their "special enrollment period",** open enrollment starts when Part B coverage begins.

Under 65 Federal Open Enrollment Rules: Disabled SSDI recipients can begin receiving Medicare before they turn 65. Under federal law, they are not eligible for Medigap open enrollment until they reach age 65. However, under Massachusetts law, any disabled Medicare beneficiary of any age can enroll during the six-month open enrollment period afforded to all new Medicare Part B enrollees. Medigap open enrollment begins on the first day of the month they become eligible for Medicare Part B.

2. Other Open Enrollment Opportunities in Massachusetts

There are a number of possible times that you can apply for a Medigap or an HMO plan if you are an eligible person under the Massachusetts rules.

A person who becomes "Initially Eligible for Coverage" has six months beginning with the first month they are initially eligible to enroll in any Medigap policy or any risk or cost contract HMO approved for sale in the state.

Initially Eligible for Coverage: a date when an eligible person

- a. first enrolled for benefits under Medicare Part B, or
- b. lost employer-sponsored health coverage due to termination of employment, employer bankruptcy, or because of the discontinuance of employer-sponsored health coverage offered to similarly situated employees, or
- c. moved out of the HMO service area, or
- d. became a resident of Massachusetts.

An eligible person is any person who is eligible for Medicare Part A and B and is enrolled in Medicare Part B regardless of age, however, Issuers and HMOs are not required to provide coverage to a person who is under age 65 and is eligible for Medicare due solely to end-stage renal disease; provided further, nothing prevents an Issuer or HMO from providing coverage to persons with end-stage renal disease.

NOTE: Persons with end stage renal disease can apply for a Medigap plan when they turn age 65.

If you want to buy a Medigap policy when one of these events happens to you, you must submit your application during the six month period beginning with the first month the event happens.

Medigap insurers and HMOs should let you apply before your 65th birthday so that your coverage will start when you turn age 65 and go on Medicare.

A person is a "late enrollee" if they do not purchase a Medigap or HMO plan during the six-month time when they are initially eligible for coverage. Late enrollees may be subject to premium surcharges for delaying their enrollment.

3. Annual Open Enrollment Period:

The annual open enrollment period for "eligible persons" shall begin on February 1st and ends March 31st of each year, for coverage to be effective June 1st of that year or no later than when Medicare coverage is first effective, whichever is earlier. Every Medicare Supplement Insurance Issuer and each HMO offering Coverage provided by a Cost or Risk Contract HMO must participate and offer every Policy or Certificate or Evidence of HMO coverage available from their company.

For the annual open enrollment period in 1995 and 1996, no surcharge can be applied against a person who is a late enrollee or who upgrades coverage.

For the annual open enrollment period in 1995 and 1996 and 1997, no surcharge can be applied against a person who upgrades coverage if he/she is upgrading from a policy or HMO plan issued to be effective prior to 1-1-95.

For the required open enrollments of 1995-1997, every Issuer and each HMO shall give its insured a written notice no later than January 1 which performs the following acts:

- a. Announces the upcoming enrollment period with the effective date of coverage of June 1,
- b. Explains that a list of all issuers and HMOs is available from the Massachusetts DOI and EOEA offices.

- c. Explains that there is no surcharge against the premium for an "eligible person" who is a late enrollee or who upgrades coverage during the annual open enrollment periods of 1995 and 1996.

4. Discounts and Surcharges: Cost Contract HMOs and Medigap Policies

Issuers of Medicare Supplement Insurance Policies and coverage provided by Cost Contract HMOs may apply surcharges to the premiums for late enrollees or people who upgrade coverage; However, there would be no surcharge for late enrollees who have had a "reasonably actuarial equivalent" prior coverage which was continuous from either the late enrollee's initial eligibility or three years prior to the effective date of the new coverage, whichever is later.

Any surcharge cannot exceed 15% and may be charged for no more than three years.

No surcharge may be used by an Issuer or HMO unless a discount is also used.

A discount on the premium may be used if an "eligible person" enrolls during the six month period beginning at the time the person becomes initially eligible for coverage after attaining the age of 65. The discount may not exceed 15% per year and cannot be used for more than three years. It shall be applied against the premium for the year.

The use of discounts or surcharges by Issuers or HMOs should be supported in their rate filing documentation and shall comply with the refund and credit calculation requirements.

Late Enrollee: an eligible person who has submitted an application for a Medicare Supplement Insurance Policy after the six month period beginning with first month the eligible person:

- a. first enrolled for benefits under Medicare Part B, or
- b. lost employer-sponsored health coverage due to

termination of employment, employer bankruptcy, or because of the discontinuance of employer-sponsored health coverage offered to similarly situated employees, or

- c. moved out of the HMO service area, or
- d. became a resident of Massachusetts.

5. Required Open Enrollment Following HMO Plan Cancellation:

If an HMO's contract with Medicare is terminated, or if the Commissioner assumes administrative supervision of an Issuer or HMO, the Commissioner will schedule a required open enrollment and every issuer of Medicare Supplement Insurance policies and every HMO with coverage provided by a Cost or Risk Contract shall participate. Such coverage issued during this required open enrollment period will become effective on the date that coverage under the terminated HMO ends.

6. Continuous Open Enrollment (Optional):

Any Issuer or HMO may elect to offer continuous open enrollment after filing with the Commissioner thirty days prior to the beginning of the enrollment period. Also, before ending the continuous open enrollment period, the Issuer or HMO must notify the Commissioner at least 60 days before the ending date.

Other Federal Requirements Concerning the Sale of Medigap Insurance

1. Pre-existing Condition Waiting Period: Federal

A pre-existing condition is one for which a doctor gave or recommended treatment within 6 months before the policy's effective date. Federal standards allow policies to exclude coverage for pre-existing conditions for up to six months.

Pre-existing Condition Waiting Period: Massachusetts

In Massachusetts, an insurer is not allowed to impose any waiting period for pre-existing conditions.

2. Guarantee issue

No Medicare Supplement Insurance policies or coverage provided by a Cost or Risk Contract HMO may deny an eligible person the issue of coverage based upon an applicant's age, health status, past claims experience, current receipt of medical care, or a chronic medical condition.

3. Coordination with Medicare

Medicare is primary (pays first), and the Medigap policy is secondary (pays towards the amounts not paid by Medicare). Policy benefits (and usually premiums) are automatically adjusted (increased) to keep up with changes in Medicare deductibles and co-payments.

4. Outline of Coverage

An Outline of Coverage is an abbreviated depiction of the policy. Its format is prescribed by federal and state regulation. These standardized outlines of coverage must accompany all solicitation materials and include the three standard plans available to Massachusetts residents. The company's chart will highlight the plans being offered and additional charts will provide details for all of the benefits in each of the plans being offered. The outline must show the premium for each of the policies the company is selling.

5. Free look provision

Beginning from the day you receive the approved policy, you have 30 days to look it over. If you change your mind, you can cancel within those 30 days and get a full refund.

6. Guaranteed Renewability

Federal law now mandates that Medigap policies be guaranteed renewable. The policy cannot be cancelled unless you stop paying the premium or misrepresent any information. The

company must continue the policy, with no changes in benefits (except to keep up with changes in Medicare).

Pre-standard policies:

People who bought pre-standard policies (any policy bought **before January, 1992**) were not affected in any way if the policy was **guaranteed renewable**. They could ignore standardization unless they wanted to switch their old policy for a standard one. They should not make such a switch without good reason. Those reasons might include better benefits or a lower premium

Exception: Some older policies were **not** guaranteed renewable and the company retains the right to "non-renew" and offer policyholders new, standardized policies.

Once a pre-1992 policy has been replaced by a new, standard policy, the old one is gone forever.

7. Medicaid provision

If you bought a Medigap policy after 11/4/91 and became eligible for Medicaid, you can **suspend** the policy for up to 24 months. During the Medicaid suspension you do not have to pay premiums.

You must request the suspension within 90 days of becoming eligible for Medicaid.

If your finances change again and you become ineligible for Medicaid (within the 24 months), you can be reinstated. You must notify the company no later than 90 days after you lose Medicaid eligibility.

8. Sales Practice Requirements for Insurers and Their Agents

Federal Medigap Reform Law also included requirements for insurance companies and their agents that are designed to protect consumers. Prior to these reforms duplicate Medigaps, Medigaps bought when an older adult already had Medicaid,

Medigaps bought when an agent used scare tactics or both without the benefits of an unbiased source of information were all common occurrences. Inappropriately sold insurance policies accounted for an estimated \$3 billion spent needlessly every year by older adults.

9. Medigap Sales and Policy Replacement

Agents must note in writing what other insurance they have sold you. Agents may not sell you a new Medigap policy unless you agree to cancel your original Medigap policy. Your new insurer must remind you within six months to terminate one of your Medigap policies.

For replacement policies the applicant is required to fill out and sign a replacement form indicating that they understand the **hazards** of changing. This is to protect consumers against frivolous policy switching.

REPLACEMENT NOTICE (STATEMENT TO APPLICANT)

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- Other. (Please specify)_____

A good policy will last many years and a person should not buy a new one just because it looks nicer or came with a smooth sales pitch.

10. Medigap Cost and Value

The cost of Medigap insurance has dramatically increased in recent years, an average increase of 28%. In a move to control the sky rocketing premiums of Medigap insurance, Massachusetts requires all premium rates to be filed with the Division of Insurance and approved by the Commissioner. Massachusetts also requires a public hearing when the Medigap insurer requests a rate increase of more than 10%.

Premiums: Beginning in 1995, Massachusetts requires issuers of Medigap policies to use community rating to set premiums.

Community Rating/No Age Rating: Premiums are the same for all customers, regardless of their age.

Age & Premiums: In other states and for policies sold prior to 1/1/95, insurance companies price Medigap policies using the community rating method or two additional methods:

- a. **Attained Age Method:** The premium is scheduled to increase automatically as you get older. If you buy at age 65, when you are 80 you will pay the same price as all of the company's 80 year-old customers.
- b. **Issue Age Method:** The premium is set when you buy the policy. If you buy at age 65, you will always pay the company's premium for 65 year olds (which will go up with each rate increase).

Reasons for Changes in Premiums

When the Division of Insurance reviews a company's rates, it looks at its **loss ratios**, what percentage of the premiums collected was actually paid in claims. Individual policies have to have a loss ratio of 65% (e.g. for every dollar the company collects from consumers, 65 cents must be paid in claims). Group policies have to meet a 75% loss ratio.

If a company's loss ratio is too low (for example, it pays only 50 cents out of every dollar on claims), the Division of Insurance will require the company to issue refunds to all customers. If it's too high, the company will be allowed to raise its rates.

Anti-Duplication Efforts to Deter Purchasing Excess Coverage

It is illegal for a company to sell a duplicate Medicare Supplement policy to an individual who already has a Medicare Supplement policy. However.....

Policies or certificates which duplicate Medicare will be exempt from the prohibition if:

- a. they pay benefits directly to the beneficiary without regard to other coverage, and
- b. the application of insurance contains a clear statement disclosing the extent to which the policies duplicate Medicare.

All types of health insurance policies that duplicate Medicare shall include a disclosure statement on the application or together with the application. The disclosure statement may not vary in terms of language or format from the defined standards

Policy types required to use a disclosure form:

- a. Accidental injury
- b. Specified limited services
- c. Cancer policies and all other specified disease(s) or the specified impairments that limit reimbursement to named medical conditions.

- d. Fixed dollar amounts for specified diseases or other specified impairments that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.
- e. Indemnity policies and other policies that pay a fixed dollar amount per day, excluding Long Term Care policies
- f. Policies that provide benefits for both expenses incurred and fixed indemnity basis
- g. Long Term Care policies providing both nursing home and non-institutional coverage
- h. Policies providing nursing home benefits only
- i. Policies providing home care benefits only
- j. Other policies not specifically identified in the previous listing
- k. Limited benefit policies and employer group health plans.

It is permissible to sell a Medigap policy to someone who has an employer plan. The employer plan is not considered a "Medigap policy" and therefore it would not violate the conditions for duplication.

No one usually needs more than one Medicare Supplement policy. If someone wants to improve their Medigap benefits, they should not **duplicate** the policy. They should **replace** it.

BUT

They should not **drop** the old policy **until they have received** the new one...That means waiting until you've actually got your hands on the new policy before you cancel the old one.

Agents and Commissions: Incentives to Sell

The sales commission is an insurance agent's sales incentive. Commission structures in the past have often given unscrupulous agents an incentive to oversell. Compare how it used to be with new rules.

Commissions in the "old days" (not real numbers)

- * Agent sells a policy with \$1,000 annual premium.
- * The first year agent gets 50% (\$500).
- * The next year the company pays the agent only 10% or \$50.
- * For each of the next 5 years the agent collects 10% (\$50).
- * To keep collecting the high first year commissions, unscrupulous agents "churned" or "twisted" the business--replacing Medigap policies as often as possible.

Commissions Today (not real numbers)

- * Agent sell a policy with \$1,000 annual premium.
- * First year commission is 25% or \$250.
- * Commission for the next 5 years must be at least 1/2 the first year--or \$125 per year.
- * The agent gets no first year commission for replacing an existing Medigap policy. All replacements are treated as "second year" commissions.

MEDICARE SELECT

A **Medicare SELECT** is private insurance that supplements traditional Medicare insurance coverage. It is a type of Medigap or Medicare Supplemental policy but just like Medigap insurance, Medicare SELECT is required to meet certain Federal standards and is regulated by the state Insurance Commissioner. The Division of Insurance is currently writing the regulations for how Medicare SELECT will work in Massachusetts.

Medicare SELECT, may be offered by insurance companies and HMOs, and is the same as standard Medigap insurance in **nearly** all respects.

The principle difference between Medicare SELECT and standard Medigap insurance is that supplemental benefits are usually provided only when the Medicare beneficiary receives care from a designated "network" provider. Each insurance company that offers a Medicare SELECT policy has its own network of providers. By restricting coverage to designated providers, Medicare SELECT insurers are able to offer policies that are up to 25% less expensive than the beneficiary would pay for the same benefit package without the network restriction.

When a Medicare SELECT policyholder receives covered services from a preferred provider, Medicare will pay its share of the approved charges and the SELECT insurer will pay the balance of the bill. Medicare SELECT policies are also required to cover supplemental charges associated with emergency health care services furnished by providers outside of the preferred provider network. Although Medicare will always cover the Medicare portion of services obtained from network and non-network providers, Medicare SELECT policies are not required to cover routine, non-emergency services received from non-network providers.

Common Medigap Problems:

1. Too much Medigap:

Person has bought more than one Medigap policy.

Solution:

- Help the insured evaluate his or her needs and keep the policy that best meets those needs.
- Client should terminate the excess coverage.
- Call the Department of Insurance and report he or she had been sold another (duplicate) policy.

2. Policy doesn't cover all medicare expenses

It's an old policy, written before modern standards.

Solution:

- Compare benefits and prices with current policies, examining possibility of replacing old with new.

3. Premiums rapidly rising:

This may be the result of being in an "old block of business"--the company has not been adding any new people to the pool of insured.

As policyholders get older, their expenses go up, the group shrinks, and prices skyrocket.

Solution:

- Shop around for a cheaper policy. If there are health problems, identify guaranteed issue policies. Also, discuss Medicare Coordinated Care (HMO) plans. If the premiums are unaffordable, then QMB, SLMB, or Medicaid might be the best solution.

4. Medigap Application rejected:

Person has history of health problems and company has rejected the application **outside the open enrollment period.**

Solution:

- Every issuer of Medigap insurance in Massachusetts must issue a policy to any applicant, without health screening, with the one exception for persons under age 65 with ESRD.

5. Unpaid claims:

Unpaid medical bills or dunning notices from doctors or hospitals, which are sure signs of Medigap claims problems.

Solutions:

- Contact the insurance company directly. Many companies have toll-free numbers. If the problems are complicated it may be best to contact the insurer in writing.
- You will need the insured's name and policy number.

- If the company has no record of the claim or says additional information is needed, ask the providers to resubmit complete claims.
- If the claim has been denied, ask that a written explanation be sent to the insured. If Medicare has paid, then the Medigap policy should pay.
- Have the insured file a complaint with the Division of Insurance if the company is uncooperative or its denial explanations are unacceptable.

CHOOSING A MEDIGAP

Should everyone enrolled in Medicare buy a medigap policy?

1. It is a common misconception that once you enroll in Medicare, you'll need to buy a Medicare Supplement or Medigap policy. Not everyone enrolled in Medicare needs a Medigap. Before legislation reformed the Medigap market, an estimated \$3 billion each year was wasted by elders who bought, but did not actually need, a Medicare Supplement Insurance policy.
 - a. If you qualify for Medicaid, you cannot be sold a Medigap policy, if you qualify for the Qualified Medicare Beneficiary (QMB) program you may not need Medigap policy unless you need prescription drug coverage. Both Medicaid and the QMB program fill in many of Medicare's gaps for those eligible.
 - b. If you are a retiree who has health insurance from your former employer, you may find it provides comprehensive coverage for a reasonable cost. A Medigap policy would, in most cases, duplicate the hospital and medical benefits offered by your retiree plan and would be a waste of dollars in premiums each year. For retirees with very limited employer-sponsored health insurance benefits, a Medigap policy may be necessary.
 - c. A person would not need Medigap if they elect Medicare coverage through an HMO. Medicare contract HMOs usually provide coverage for most health care needs.

Medicare Supplement ("Medigap") Insurance Comparison Charts

Three Standard Medigap Plans Sold in Massachusetts

Comparison of Plans	Core	Supplement 1	Supplement 2
Basic Benefits Included In All Plans:			
Hospitalization Part A Copayments			
Days 61 - 90: \$190 per day	X	X	X
Days 91-150: \$380 per day	X	X	X
365 Additional Lifetime Hospital days - Paid in full	X	X	X
Part B Coinsurance	X	X	X
Coverage of coinsurance, in most cases, 20% of approved amount	X	X	X
Parts A and B Blood			
First 3 pints			
Additional Benefits	Core	Supplement 1	Supplement 2
Part A Deductible for Hospital Days 1 - 60		X	X
\$760 per benefit period			
Skilled Nursing Facility Coinsurance		X	X
Days 21-100 - \$95 per day			
Part B Annual Deductible - \$100.00		X	X
Foreign Travel - For Medicare-covered services needed while traveling abroad.		X	X
Inpatient Days in Mental Health Hospitals In addition to Medicare's coverage of 190 lifetime days and less any days previously covered by plan in same benefit period	60 days per calendar year	120 days per benefit period	120 days per benefit period
Outpatient Prescription Drugs **			
From Retail Pharmacies after a you meet a \$35 calendar quarter deductible:			X
<ul style="list-style-type: none"> 100% coverage for generic drugs 80% coverage for brand-name drugs 			
State-Mandated Benefits: Annual Pap Smear Tests and Mammograms not covered by Medicare (in off-year) Check your policy for other state-mandated benefits	X	X	X

**** These drugs include:** injectible insulin needles and syringes; pumps and pump supplies necessary for the administration of insulin and materials, and equipment used to test for the presence of sugar; drugs provided by a home infusion therapy provider; and drugs used on an off-label basis for the treatment of cancer or HIV/AIDS and medically necessary services associated with the administration of such drugs.

Medicare Supplement ("Medigap") Insurance Comparison Charts

1997 Monthly Premiums for Medicare Supplement Insurance

Please Note: Rates may change in 1997. Call company for current rates.

Insurance Company	Time of Year Selling *	Core	Supplement 1	Supplement 2
Banker's Life and Casualty 1-508-477-2800 Cape Cod area 1-508-820-8301 Eastern Mass. 1-413-739-7696 Western Mass. Offers premium discount when initially eligible; also offers discount when using automatic bank withdrawal.	Continuously Throughout Year - Open Enrollment	\$53.48	Not Offered	\$157.08
Banker's Multiple Line 1-800-792-4368 Offers discount when using automatic bank withdrawal; does not offer discount when initially eligible.	Selling Up Through 1-31-97 Only	\$43.61	\$72.15	\$107.34 Proposed rates 1997: \$226.44 Drug Mail-Order Option
Blue Cross & Blue Shield 1-800-258-2226 1-617-376-4700 Offers discount when initially eligible.	February - March	\$41.29 Proposed rates for 1-1-97: \$54.76	\$81.03 Proposed rates for 1-1-97: \$96.09	\$182.70 Drug Mail-Order Option Proposed rates for 1-1-97: \$236.30
Mutual of Omaha Life Insurance 1-800-995-9163 No premium discount program.	Selling Up Through 1-31-97 Only	\$43.12	\$79.69	\$166.00
New York Life Insurance 1-800-995-7445 No premium discount program.	Selling Up Through 1-31-97 Only	\$43.12	\$79.69	\$166.00
Hartford Life Insurance ** For Retired Officers Association and Association of the United States Army only TROA: 1-800-247-2192 AUSA: 1-800-882-5707 No premium discount program.	Continuously Throughout Year - Open Enrollment	\$41.00	\$74.00	\$139.00
Prudential - AARP ** For American Association of Retired Persons (AARP) members only 1-800-523-5800 Offers discount when using automatic bank withdrawal.	Continuously Throughout Year - Open Enrollment	\$47.00	\$89.25	\$173.50 Proposed rates for 1-1-97: \$225.25

*A 6-Month Open Enrollment period may be in effect for persons who are "Initially Eligible for Coverage", meaning someone who first enrolls into Medicare Part B; or someone who just moved to Massachusetts; or someone who was covered by an HMO but just moved out of the previous plan's service area; or, someone who has lost their health insurance coverage from their employer because their job ended or their employer stopped offering coverage to employees like them.

** These plans are only available through membership in the associations indicated.

(Rev: 1/97)

How to Choose a Medigap /Counseling techniques:

Choosing a medigap plan that is best for a person requires a three part study:

1. the policy benefits,
2. the insurance company's reputation, reliability, and financial status, and
3. the premium.

When counseling a client the following techniques and information should be provided:

1. Compare two current policies. Remember, these policies have basic requirements which make their benefits coverage exactly the same or almost the same.
2. The big differences in these policies exist in the following coverage areas and these benefits largely determine the cost of the insurance premium:
 - a. Part A deductible
 - b. Skilled nursing co-payment
 - c. Part B deductible
 - d. Prescription drug coverage
3. Make sure the client understands what Medicare pays and does not pay.
4. In Massachusetts, it usually does not make sense to buy a policy that covers excess charges because of the "**ban on balance billing**", unless you spend a significant amount of time out of Massachusetts.

5. When someone is buying a Medigap policy for the first time or replacing an already existing policy be aware of when the coverage becomes effective.
6. The insurance company must include an **outline of coverage** with every Medigap application. The first page of the outline is the three-plan chart, highlighting the plans that the company is selling. It also includes the premium for each plan and more detailed charts showing what benefits are add to Medicare coverage.

Three plan chart: The three-plan chart is helpful when used as a comparison sheet. Although benefits are not priced separately, by comparing benefits and prices you can get a fair idea of how much it costs to add each of the benefits to the company's "Core" (basic) plan.

7. **Additional counseling tips:**
 - a. Explain no Medigap policy fills all the gaps.
 - b. Do not buy more than one policy.
 - c. Pay by check, not cash! And, make the check payable to the company, never the sales agent.
 - d. Do not be rushed....remind the client they are entitled to a - 30 day free look period. They may return the policy during this time and get a full refund of their money.

Comparing Non-Standard and Standard Medigap and HMO Plans

Plans sold prior to 1995 may or may not have benefits found in standard Medigap or HMO plans sold after January 1, 1995.

Present Plan / Standard Plan Being Considered

Items To Compare Between My Current Plan and the Standard Medigap Plans or HMO Senior Plans	Yes	No	GAP Yes or No	HMO Yes or No	Did I Use Benefit Last Year?
MEDICARE PART A: HOSPITALIZATION					
Part A Deductible	—	—	—	YES	—
Hospital Copay for day 61-90	—	—	YES	YES	—
Hospital Copay for day 91-150	—	—	YES	YES	—
Hosp. coverage for 365 add'l days	—	—	YES	YES	—
Nursing facility copay for day 21-100	—	—	—	YES	—
First 3 pints of blood	—	—	YES	YES	—
MEDICARE PART B: MEDICAL EXPENSES					
Part B Deductible	—	—	—	YES	—
20% of Medicare Approved Charges	—	—	YES	YES	—
OTHER EXPENSES					
Foreign travel	—	—	—	—	—
Prescription Drugs-Pharmacy	—	—	—	—	—
Mail Order	—	—	—	—	—
Annual Physical	—	—	—	—	—
Routine Office Visits	—	—	—	—	—
Eye Wear/Glasses	—	—	—	—	—
Hearing Aids	—	—	—	—	—
Dental Benefits	—	—	—	—	—

SERVICES AND CONDITIONS	Present	Plan	Standard	Plan	
Community Rated Premiums	___	___	YES	YES	___
Age Rated Premiums	___	___	NO	NO	___
Guaranteed Renewable	___	___	YES	YES	___
Life-time Maximum benefits	___	___	NO	NO	___
Guarantee Issue(no health screen)	___	___	YES	YES	___
Has Toll-Free Telephone number	___	___	___	___	___
PREMIUMS PLUS ADDITIONAL COSTS					
Monthly Premium	___	___	___	___	___
Yearly Premium	___	___	___	___	___
Office Visit Copayment	___	___	___	___	___
Prescription Drug Copayment	___	___	___	___	___

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CLAIM PROCESSING

1. Crossover and claims handling:

Cross over of claims from a Medicare carrier or intermediary to the Medigap insurance company can be a great benefit for the Medicare beneficiary because they do not have to handle all the claims paperwork related to Medicare covered services.

Claims are processed only after Medicare has made payment on the claim submitted to the intermediary or carrier. The Explanation of Medicare Benefits (EOMB) indicates the amount of deductible or co-payment for which the policyholder is responsible.

After Medicare pays its share of the bill, it will send a record of the claim, either a Benefit Notice or an EOMB, directly to the insurance company instead of the consumer.

However, crossover is available **if and only if:**

- a. the Medicare beneficiary uses a Medicare Participating Provider; **and**
- b. the provider includes the name of the Medigap insurance company on the claim form and checks a box indicating that the claim is to be paid directly by the insurance company to the provider.

This is not automatic. The patient must make sure the doctor puts the necessary information on claim forms.

2. Medicare Payment: is made directly to the doctor who accepts assignment.

A list of participating physician and medical providers, called **MEDPARD**, is available from the Medicare carrier.

Medicare payment is sent to the beneficiary when physicians do not accept assignment. Many physicians do not accept assignment. These physicians often bill the patient (Medicare beneficiary) at the same time they bill Medicare. The patient receives a reimbursement payment directly from Medicare which indicates the percentage or amount of the total bill that will be paid by Medicare.

3. Filing claim for Medigap payment:

The patient sends a copy of the EOMB to the Medicare supplement carrier for payment under the policy. (When "cross over of claims" occurs, the insurance companies receive the information directly from Medicare.)

Sometimes, non-participating providers who accept assignment bill the insurance company directly.

The patient may have paid at the time of receiving the medical service. Sometimes, the patient is allowed to wait and receive the Medicare reimbursement for Medicare covered services. Then, the patient pays the doctor what they receive from Medicare and the insurance company too, plus any difference for the provider's charge (excess charge).

4. Contesting a Medicare Supplement payment:

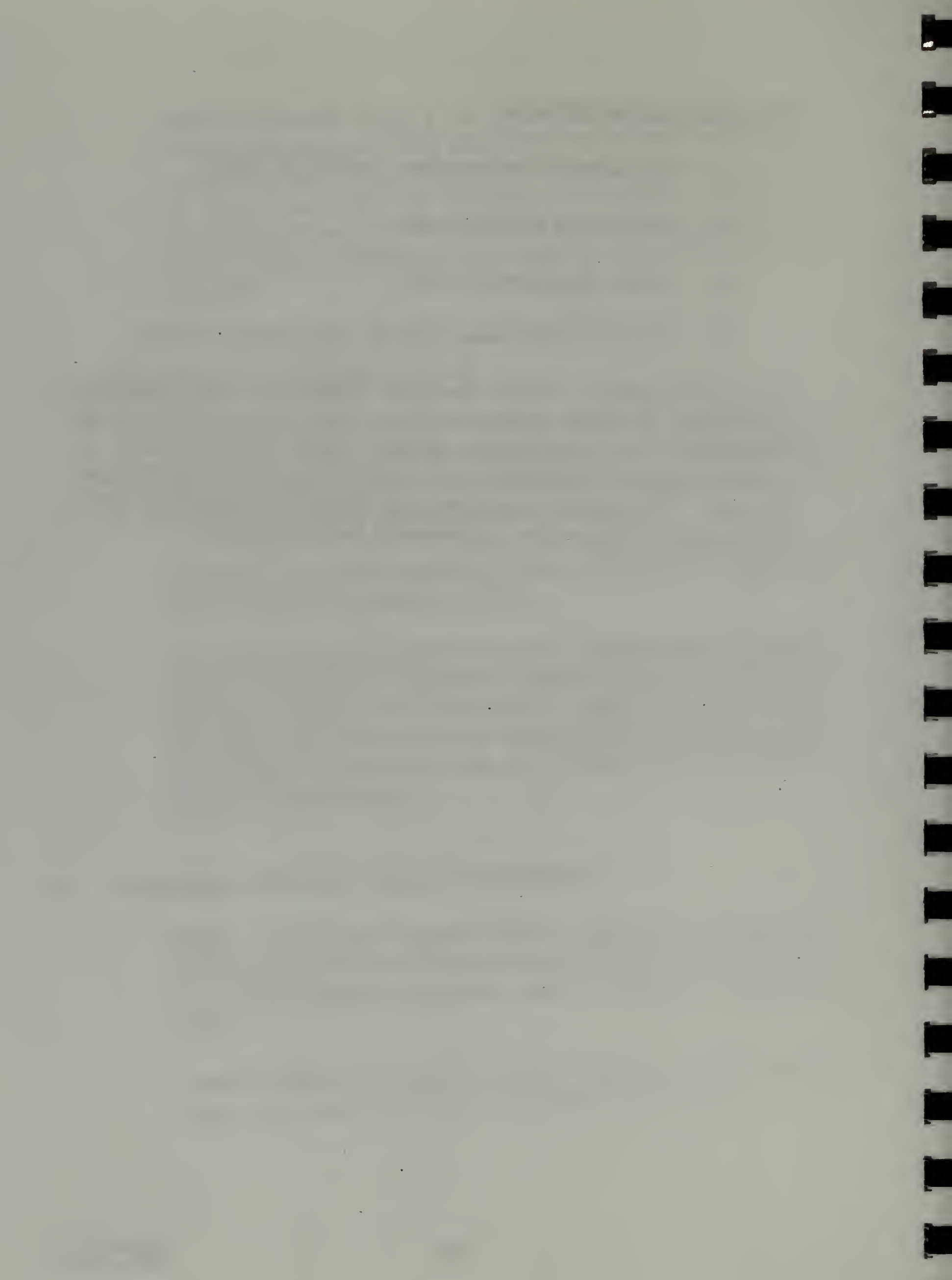
While the Medicare Appeals process applies only to Medicare benefits and payments, there may be occasions in which questions are raised regarding payments under a Medicare supplement policy.

A policyholder may contest an action because payments were not made according to the benefits described in the policy.

The complaint should state:

- a. the nature of the procedure, service or supply
- b. the amount Medicare paid,
- c. policy provisions or limits,
- d. why the policyholder feels the claim should be paid.

Any correspondence with the Medicare Supplement carrier regarding a complaint should be accompanied by a copy of the EOMB and the supplement's claim processing number, along with the policy or contract number. The EOMB is the patient's only record of Medicare payment. The patient should keep the original or the EOMB and a copy should be sent to any supplemental carrier involved.



MEDIGAP EXERCISE

At the age of 66, Henry is still working full-time. He has Medicare Part A and has group coverage in an HMO plan through his employer. Henry will be retiring on March 15, 1996.

Henry calls SHINE and wants to know when he should enroll in Part B?

1. Will he incur a penalty? _____ If yes, how much? _____

2. Who should Henry contact to enroll in Medicare Part B?

_____ tel: _____

3. Henry would like to know who sells Medigap insurance and what are the monthly premiums for plans with prescription coverage?

4. Henry has been notified his Medicare Part B will be effective on April 1, 1996. What is the period of time Henry will be initially eligible to enroll into a Medigap plan? _____

CHAPTER 10

The first part of the chapter discusses the importance of the

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MEDIGAP EXERCISE

Beth will be 65 years old on December 14, 1995. She has been collecting Social Security for three years. She calls SHINE and wants to know if she should contact any agency to enroll into Medicare. _____

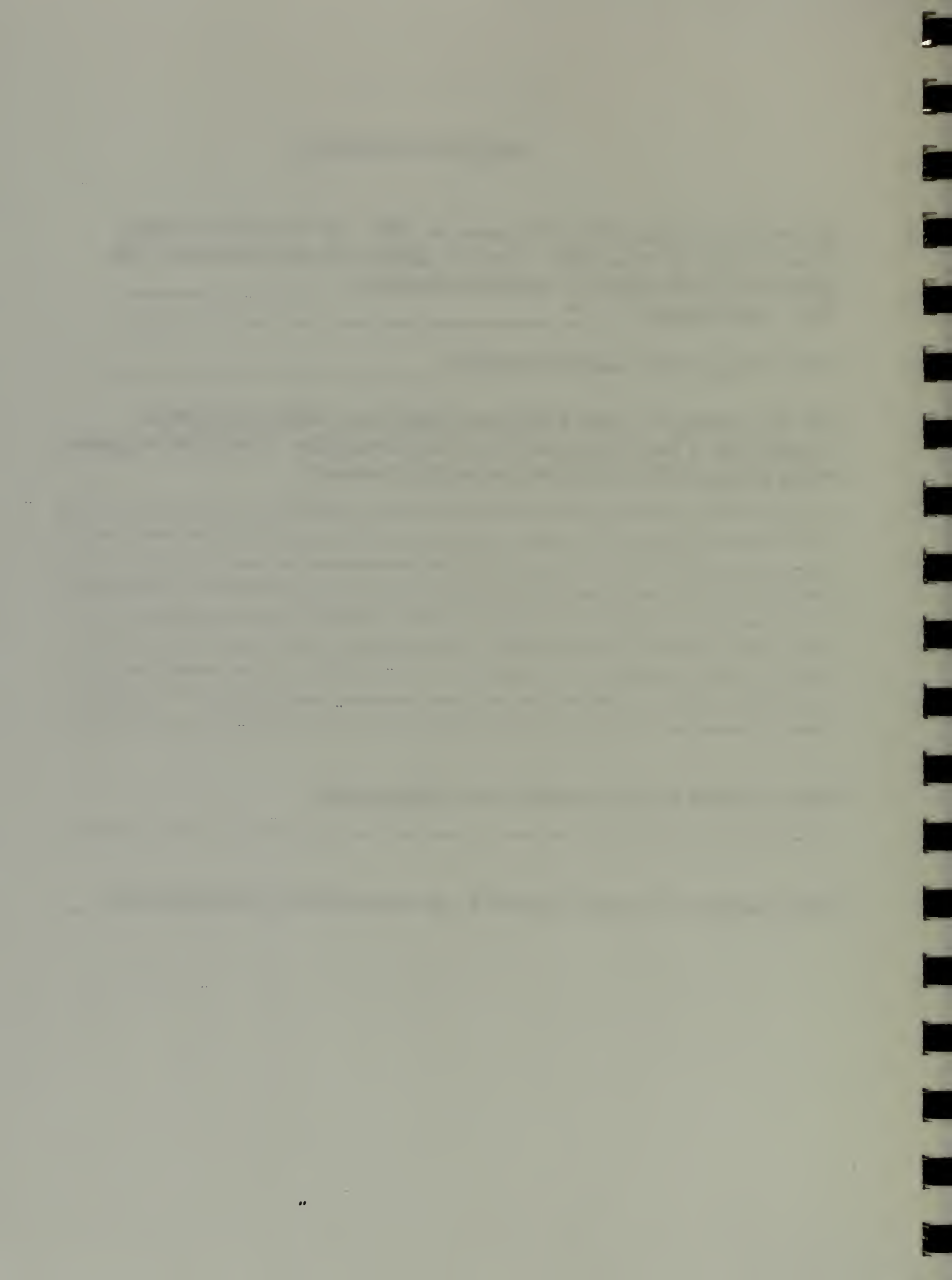
If yes, which agency? _____

What is Beth's initial enrollment period? _____

Beth has decided she wants a Medicare Supplement without prescription coverage, but it has to cover the Part A & B deductibles. List all the companies selling this type of coverage and the monthly premiums.

When will Beth be able to enroll into a Medigap plan?

If she decides not to enroll into Part B, can she enroll into a Medigap plan? ____



HEALTH MAINTENANCE ORGANIZATIONS (HMOs).

TOPICS:

- . INTRODUCTION**
- . HOW MEDICARE HMOs WORK**
- . PRIMARY CARE PHYSICIANS**
- . TYPES OF HMOS**
- . CONTRACTS WITH MEDICARE**
- . ELIGIBILITY**
- . ENROLLMENT**
- . HMOs AS AN ALTERNATIVE TO MEDIGAP**
- . DISENROLLMENT**
- . GENERAL GRIEVANCE and APPEAL PROCEDURES**
- . ADVANTAGES/DISADVANTAGES OF HMOs**
- . HMO CHECKLIST**

A. INTRODUCTION

Medicare beneficiaries can **choose** to receive their health care services either through the traditional "fee-for-service" delivery system or through managed care plans that have contracts with Medicare.

In the "fee-for-service" system, a Medicare beneficiary can go to any licensed physician and use the services of any hospital, health care provider or facility certified by Medicare. Generally, a fee is paid each time a service is used. Currently, about 90% of all Medicare beneficiaries use the fee-for-service plan.

Although Medicare pays a large portion of the hospital and medical expenses, the beneficiary is responsible for deductibles, coinsurances, permissible charges, and services not covered by Medicare. While many people purchase private Medigap insurance to supplement their Medicare coverage, others are looking more closely at managed care plans that have contracts with Medicare.

Managed care plans are an alternative to traditional Medicare and might be thought of as a combination insurance company and a health care delivery system (doctor/hospital). Like an insurance company, they cover health care costs in return for a monthly premium, and like a doctor or hospital, they provide health care services.

Health Maintenance Organizations (HMOs) are a form of managed care. Each HMO plan has its own network of hospitals, skilled nursing facilities, doctors and other health care professionals to provide services to its members. HMOs are usually owned by corporations, hospitals or business groups. This chapter will cover **Medicare-contracted** Health Maintenance Organizations (HMOs) available for sale in Massachusetts.

B. HOW MEDICARE HMOs WORK

Medicare HMOs are an alternative choice to traditional health insurance for Medicare beneficiaries who meet the HMO eligibility requirements. HMOs contracting with the Medicare program must provide or arrange for the full range of Medicare Part A and Part B services including hospitalization, physician services, skilled nursing and home health care. Some HMOs also provide benefits beyond what Medicare covers, such as preventive care, prescription drugs, dental care, hearing aids and eyeglasses.

1. The Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services approves or disapproves the applications submitted by HMOs to become Medicare Certified Contracting HMOs. This contract allows Medicare to make a monthly payment upfront to the HMO for each enrollee.
2. Medicare HMOs have an established network of hospitals, skilled nursing facilities, doctors and other health care professionals. Some of the larger plans have their own hospitals and other health care facilities. HMOs usually require their members to receive all health services from the HMO's network. These services are provided within a geographical service area that is defined by the HMO plan. The HMO will specify

the member's geographical service area and relate it to the member's residential address.

- a. An HMO service referral area includes those communities in which an HMO is **authorized** by the federal government to offer its Medicare contracted plan. Therefore, Medicare HMOs plans may have a different network of providers than HMOs available through employers. For example, the directory for Tufts Secure Horizons is not the same as the directory for Tufts Associated Health Plan.
2. Depending on how the plan is organized, the services are usually provided either at one or more centrally located health facilities or in the private practice offices of the professionals affiliated with the plan.
3. HMO plans generally charge enrollees a monthly premium. Premiums vary from plan to plan and are subject to change annually. Medicare beneficiaries must also continue to pay the Part B monthly premium.
4. HMO plans commonly charge small copayments for certain services, (instead of the deductibles and coinsurances charged in the fee-for-service system).

C. PRIMARY CARE PHYSICIAN

The primary care physician is a doctor, usually a family practitioner or an internist, who authorizes, arranges for and coordinates all covered services for the HMO member.

1. In most cases, when a Medicare beneficiary joins an HMO, they will be asked to select a **primary care physician** in their geographical area, who is affiliated with the HMO. Each HMO provides a list of physicians participating in the HMO network.
2. Primary care physicians (PCPs) are responsible for managing their

patients' medical care and admitting them to a hospital. Referrals are usually made to those specialists affiliated with the same hospital as the PCP. If for any reason a beneficiary wants to change their PCP, they can do so by simply writing or calling the HMO Member Services Department. In most cases, the change will take place on the first day of the following month, or a future date, if requested.

3. HMO directories are a good resource in determining the "**referral circle**", which is the specific hospital and specialists (not always listed) the HMO member will have access to based on the primary care physician selected.
4. To go outside the surrounding HMO referral circle or outside the HMO network, the HMO member must obtain prior authorization from the primary care physician, **except for emergency care (anywhere) or services urgently needed while out of the plan's service area.**
 - a. Emergencies are those situations when a person needs medical care **immediately** because of a sudden illness (or worsened illness) or injury; and, the time needed to reach the HMO doctors or hospitals could increase the risk of serious harm or permanent damage. It is an unexpected or unforeseen condition. Examples include a fractured limb, suspected heart attack, excessive bleeding or stroke.

In an emergency, it does not matter if the person is inside or outside of the HMO's service area. They should go to the nearest hospital or other health care provider to seek and receive care. The HMO will pay for the out-of-plan emergency care, but the member may be charged a copayment. Most HMO plans waive the emergency room copay if the person is hospitalized overnight.

There may be occasions when the HMO plan will refuse to pay for emergency care if the HMO does not agree it was an emergency. In this situation, the member has the right to appeal the plan's decision.

- b. HMO plans will pay for out-of-area urgently needed care if the member has an unexpected illness or injury while they are temporarily outside the plan's service area. Examples of urgent care are a sprained ankle, a high fever, or a cut requiring stitches.

The HMO plan will cover urgently needed care if all of the following conditions apply:

- * the care received is unexpected (the member could not have known they would need this care);
- * the member is **temporarily** outside of the service area;
- * the illness or injury requires medical attention to prevent serious harm or the health condition to worsen;
- * the medical care needed cannot be delayed until the member returns to the service area.

If urgent care is needed while the member is **inside the plan's service area**, they should contact the HMO plan or their primary care physician for instructions on what to do in their particular situation.

After treatment is sought for emergency or urgent care outside the service area, the member should contact the PCP to arrange for any follow-up care needed. Some HMO plans may require the member to call the HMO within 48 hours of receiving emergency or urgent care. Neither the HMO plan nor Medicare will pay for any follow-up care which is not authorized by the PCP.

To learn more about what's covered in emergency and out-of-area urgent care situations, Medicare beneficiaries should read the HMO materials sent to each member. These materials outline the rules of the plan and the benefits the plan provides.

D. TYPES OF HMOs

There are different types of HMOs, including **STAFF, GROUP, NETWORK, INDIVIDUAL PRACTICE ASSOCIATION (IPA) and DIRECT CONTRACT MODELS**. Some plans do offer a mix of these models.

1. STAFF MODEL

The physicians and providers all work within one free-standing building. They are considered employees of the HMO and receive a salary. HMO members receive basically all of their medical services through a Staff Model HMO including physician, radiology, laboratory, physical therapy and prescription drugs. Inpatient treatment is still handled by an affiliated hospital.

2. GROUP MODEL

A Group Model HMO may also maintain its own health centers, but contracts with a physician group (or groups) for medical services. The physicians in the group share facilities, equipment medical records, and support staff, but are not employed by the HMO. Most of the medical services can be received through a Group Model HMO, but they may not be as extensive as a Staff Model HMO. Depending upon the arrangement, the group practice will either exclusively treat HMO members or a combination of HMO and private patients.

3. NETWORK MODEL

Similar to a Group Model, the HMO will contract with more than one group practice and form a network of groups to deliver physician and medical services.

4. INDIVIDUAL PRACTICE ASSOCIATIONS (IPA) MODEL.

In this model, an HMO will contract with an association of physicians and providers to deliver physician and medical services. These providers work in private practice and retain their separate offices and identities, but maintain a collective bond with other providers in their area.

The purpose of the association is to contain referrals of patients and to aid in negotiations with the HMO. Providers are not restricted to belonging to only one HMO. The member selects one physician as their primary care provider who then serves as a gatekeeper for access to additional services provided by the HMO.

5. DIRECT CONTRACT MODEL

HMOs contract on a one-to-one basis with providers who are in private practice, rather than through an association. As in the IPA Model, members select one primary care provider who refers them to additional services provided by the HMO.

E. CONTRACTS WITH MEDICARE

HCFA approves three types of contracts between itself and HMOs. The type of contract an HMO has with Medicare is relevant to how the HMO is paid/reimbursed by the federal Medicare program.

1. RISK CONTRACTS

In a **RISK contract**, Medicare pays the HMO **upfront** a monthly premium for each member. This payment varies by geographic location, by plan, by inpatient status and whether the enrollee has end-stage disease or is a working aged individual. HCFA calculates the plan payment based on what Medicare would have paid for the individual if he or she had received services under the fee-for-service program less five percent. The HMO plan may charge each member a monthly premium and copayments for specific services received.

The HMO and the primary care physicians both take the "RISK" that each patient's health care cost will not exceed the premiums received. If it does, the HMO absorbs the additional cost.

IMPACT ON MEMBER

- a. HMO plans with risk contracts have restricted access or a "lock-in" provision. This means that a member is generally **locked into** receiving all covered services through the plan or through referrals by the plan.
- b. With few exceptions, if a member goes outside the plan's network for services, neither the plan nor Medicare will pay for those services. **The member will be responsible for the entire bill!**
- c. The only exceptions are for emergency services, which are received anywhere in the United States, and urgently needed care received while temporarily away from the plan's service area. Currently, most HMOs cover emergency care worldwide.

Many of the HMO plans available for sale in Massachusetts have risk-based contracts, including Blue Care 65, Fallon, Harvard First Seniority, Pilgrim Prime 65, Tufts Secure Horizons, United SeniorCare and U.S. Healthcare.

2. COST CONTRACTS

HMOs with **COST contracts** are paid an upfront amount by Medicare to provide hospital and medical services. If the plan provides more services than what the fee covers, Medicare reimburses the plan the difference at the end of the year.

IMPACT ON MEMBER

- a. In a cost contract plan, the member is **not locked** into receiving services from the plan. While the plan will not pay if a member receives unauthorized care out of the HMO network, **Medicare will still pay its share for covered services**. In such instances, the member would be responsible for paying Medicare's copayments, deductibles and other permissible charges, just as if they were receiving care under the traditional fee-for-service system.
- b. Harvard Care Plus has a cost contract with Medicare.

3. HEALTH CARE PREPAYMENT PLANS (HCPP)

In addition to its risk and cost contract plans, Medicare has agreements with **Health Care Prepayment Plans (HCPP)**. With HCPP-based contracts, Medicare reimburses the HMO for the reasonable cost for providing Medicare Part B services and the providers of Part A services are reimbursed directly from Medicare.

IMPACT ON MEMBER

- a. **Medicare enrollees have the flexibility to go outside the plan** for any medical or hospital services and Medicare will pay its share for covered services. As in the cost-based plans, the member would be responsible for the deductibles, copayments and other permissible charges.

- b. Community Health Plan, HMO Blue, and Kaiser Foundation Medicare Plus currently have HCPP contracts with Medicare but are no longer accepting applications for enrollment as of 1/1/96.
- c. Community Health Plan and Kaiser have filed applications for new contracts with HCFA. As soon as they are approved, counselors will receive an update.
- d. HMO Blue has filed and received approval for a risk contract. The two plans are called Blue Care 65 Value and Blue Care 65 Value Plus (with drug coverage).

F. ELIGIBILITY

To join an HMO a person:

- 1. Must be at least enrolled in Medicare Part B and continue to pay the Part B monthly premium
- 2. Must live in the HMO's service area for at least nine (9) consecutive months each year.
- 3. Cannot have permanent kidney failure known as End Stage Renal Disease (ESRD).
- 4. Cannot be receiving hospice care from a Medicare-certified hospice program.

A federally approved HMO is not allowed to deny membership to a Medicare beneficiary for any other health conditions (for example, cancer, heart disease, etc.) except the two situations mentioned above. An HMO cannot require a health questionnaire be completed as a prerequisite to joining.

NOTE:

1. If a person elects hospice care for a terminal illness **after** joining a Medicare HMO plan, they will be required to receive hospice services from a Medicare-approved hospice. But, they may continue their enrollment in the Medicare HMO plan. The HMO plan will continue to provide and arrange for all covered health care unrelated to the terminal condition. Medicare will pay the hospice agency.
2. If after joining an Medicare HMO plan, a person is medically determined to have end-stage renal disease, the plan is required to provide or arrange for all their medical care.
3. If a person with end-stage renal disease is a current member of an HMO plan when they first become eligible for Medicare and the plan has a Medicare contract, they will be able to change to Medicare membership within the same HMO. The application to transfer enrollment must be made within six months of the effective date of their Medicare Part B.

G. ENROLLMENT

HMOs are required by the Federal Government to hold a 30-day open enrollment period each year. In addition to the federal open enrollment requirement, the State of Massachusetts also requires a two month open enrollment period (every February and March). These two requirements coincide.

Currently all Medicare HMOs available for sale in Massachusetts have continuous open enrollment (as of 3/1/96). This means a Medicare beneficiary who meets the HMO eligibility requirements may enroll in a Medicare HMO at anytime during the year. However, existing members changing from a plan with no drug coverage to a plan **with drug coverage within the same HMO** may do so only in February and March each year.

1. If a Medicare beneficiary meets the eligibility requirements, they cannot be denied membership by the HMO during open enrollment because of poor health or a disability.
2. Coverage will begin no later than 90 days from the date the HMO received the completed application.
3. The HMO plan must give each member written information explaining the benefits, the costs and the effective date of enrollment.
 - a. The premium rates for Medicare HMO plans are reviewed by both the Federal Government and the Massachusetts Commissioner of Insurance. If HMO plans have a cost contract or have a HCPP agreement with Medicare and request a rate increase of ten percent or more, Massachusetts law requires that a hearing be held by the Commissioner, just the same as for the Medigap plans.
4. HMOs are required to present members with written notice of their appeal rights.
5. If the HMO plans to eliminate any additional benefits, (over and above what Medicare requires of the HMO), the federal government requires a written notice of 90 days and the HMO member has to be notified in writing 60 days prior to the benefit being eliminated.

HMOs are required to submit all enrollment applications to the Health Care Financing Administration to confirm a Medicare beneficiary is "eligible" to enroll in a Medicare-contracted HMO plan.

Medicare beneficiaries should be encouraged not to drop any other health insurance they may have until they receive a written confirmation from the HMO their application has been approved. This notice will indicate the date in which coverage under the HMO plan will begin.

H. HMO AS AN ALTERNATIVE TO MEDIGAP

Anyone who has a Medigap policy and then decides to enroll in a Medicare HMO plan may either keep the Medigap policy or, if they decide they like the Medicare HMO plan, may cancel the Medigap policy. In general, a Medigap policy is not necessary because the HMO provides a full range of benefits.

1. A Medigap policy will be of little or no value if the Medicare beneficiary is enrolled in a risk-based HMO. The reason being, if they go outside the HMO network for Medicare covered services, **neither Medicare nor a Medigap policy will pay benefits** (except, if applicable, for prescription coverage and foreign travel). However, if the HMO plan is a cost or HCPP contract, and the enrollee receives covered services out of the HMO network, the Medigap policy may pay the Medicare deductibles and coinsurances, depending on the type of Medigap policy (i.e. Supplement One and Two would cover these amounts).
2. Until recently, Medigap insurers would have been prohibited from selling a Medigap policy to a Medicare beneficiary who was already enrolled in a Medicare HMO plan because it would duplicate benefits. However, this is no longer true.

I. DISENROLLMENT

To voluntarily disenroll for any reason, the member should state in writing that they want to withdraw from the HMO plan and return to traditional Medicare coverage. The request should include the member's ID number (which appears on the HMO card) and their Medicare card number. The request should be signed, dated and submitted by mail or in person to the HMO's administrative office or to the local Social Security office or, if appropriate, the Railroad Retirement Board office. Coverage under Medicare fee-for-service will begin the first day of the following month.

1. If a person wishes to change from one Medicare HMO plan to another, they may do so by simply enrolling in the other plan. The person will automatically be disenrolled from the first plan.
2. If an HMO member moves out of the plan's service area, they must contact the HMO to disenroll immediately and either return to fee-for-service Medicare or enroll in a HMO plan that serves their new location.

SHINE counselors should advise HMO members to contact the HMO plan to verify if the HMO received their request to disenroll and to confirm the effective date of disenrollment.

J. GENERAL GRIEVANCE and APPEALS PROCEDURES

If the HMO member is dissatisfied with the care provided by the primary care physician or has a complaint, the member should first discuss the problem directly with the physician. If the problem cannot be satisfactorily resolved, the member should review and follow the **written Member Grievance Procedure** (given to the member upon enrollment in the HMO plan).

If the member decides to change their primary care physician, they can do so by calling the HMO. Before the change can be made, the member will need to select another primary care physician from the HMO directory. Always check with the physician to see if he/she is accepting new patients.

There may be instances when an HMO plan does not consider a service to be medically necessary (i.e. home health services) or will not pay for services received. HMO members have the right to appeal these decisions.

HMO APPEALS

(For all cases except an expedited review of early hospital discharge.)

If a member is dissatisfied with the medical service decisions of the HMO Plan, (for example, they feel they were denied a service or benefit they were entitled to) and wishes to appeal, the member should:

Step 1 - RECEIVE NOTICE OF INITIAL DETERMINATION

Under the law, the HMO must give the member a written denial if the treating physician refuses to provide or authorize a covered service. Tell the physician to put the denial in writing. Typically, the HMO will send the member a **Notice of Initial Determination**. Along with this notice, the HMO is required to provide a written explanation of the appeal rights.

Step 2 - REQUEST RECONSIDERATION

The member will have 60 days from the date of this "Notice" to request a reconsideration. The member can simply write on the notice "Please reconsider" or write a letter requesting a review. The letter should be signed, dated and submitted by mail or in person along with a copy of the Notice of Initial Determination to the HMO plan.

Step 3 - RECEIVE RECONSIDERATION DETERMINATION

The HMO must reconsider its initial determination to deny payment or services within 60 days. During this appeal process, the member may decide to continue receiving medical services that are under appeal such as home health service. If the appeal is ultimately denied, the member will be responsible for the bill.

Step 4 - HMO REQUESTS REVIEW BY NETWORK DESIGN GROUP

If the HMO denies the appeal, it automatically gets sent for review to an independent group contracted by Medicare, called the Network Design Group (NDG). NDG reviews the HMO medical records and may consult independent experts.

Step 5 - NDG DETERMINATION

It can take up to five months to receive a determination from NDG.

Step 6 - REQUEST HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE

If the NDG agreed with the HMO and the member wishes to continue the appeal process, a letter should be sent to the Social Security Administration, requesting a hearing before an Administrative Law Judge. The amount in question must be at least \$100. You have 60 days from the date of NDG's notice. The ALJ has two years to make a determination.

Step 7 - APPEALS COUNCIL

Few cases go beyond the ALJ level, but if someone wishes to appeal further, they should write a letter to the Appeals Council of the Social Security's Office of Hearings and Appeals. Beyond the Appeals Council, they may file a suit in federal district court.

HMO APPEALS FOR EARLY HOSPITAL DISCHARGE

If an HMO member feels they are being discharged from the hospital too soon, they should request a written Notice of Non-Coverage from the HMO, and then appeal the discharge to the Peer Review Organization (MassPro) by noon of the next business day after receipt of the notice.

The HMO member will not be responsible for payment of hospital days stay until noon of the day after MassPro makes its decision, regardless of the outcome of the decision.

If the HMO member did not request a review by noon of the first working day after receipt of the Notice of Non-Coverage, they may appeal the determination through the HMO's reconsideration process.

1. The member must file the request to appeal the Notice of Non-Coverage in writing with the HMO, or with the Social Security Office or, if appropriate, with the Railroad Retirement Board. The HMO member has 60 days from the date of the notice to appeal. The request may be filed in writing or in person.
2. If the HMO does not rule fully in the member's favor, the appeal will be automatically be sent to the Network Design Group for review. The appeals process at this point is the same as described earlier. (see STEPS 4 through 7)

IT IS IMPORTANT TO REMEMBER, AN HMO MEMBER IS ENTITLED TO, AT A MINIMUM, THE SAME BENEFITS, SERVICES AND RIGHTS AS ANY MEDICARE BENEFICIARY.

Medicare HMO Benefit Comparisons

HMO	Type	Monthly Premium		Outpatient Prescription	
Plan Name	Risk/Cost	no Rx	with Rx	Copay	
Fallon Community Health Plan					
Senior Saver	Risk	\$0		30 Days:	90 Days:
Senior Preferred	Risk		\$72.50	\$2 Generic	\$6 Generic
				\$5 Brand	\$15 Brand
HMO Blue					
Blue Care 65 - Value	Risk	\$0 to \$30*		Health Ctr:	Pharmacy:
Blue Care 65 - Value Plus	Risk		\$60 to \$90*	\$5 All	\$5 Generic
As of 3/8/96, these plans are not available for sale.					\$10 Brand
Harvard Community Health Plan					
First Seniority	Risk	\$0 or \$42*			
with drug benefit	Risk		\$69 or \$111*	30 Days:	90 Days:
				\$5 All	\$10 All
Harvard Community Health Plan of New England					
Care Plus	Cost	\$65			
with drug benefit	Cost		\$112	30 Days:	90 Days:
				\$5 All	\$10 All
Pilgrim Health Care					
Prime 65 - Option A	Risk	\$0 or \$61.74*		30 Days:	90 Days:
Prime 65 - Option B	Risk		\$68.83 or \$130.57*	\$3 Generic	\$8 Generic
				\$9 Brand	\$15 Brand
Tufts Associated Health Plan					
Secure Horizons	Risk	\$0			
with drug benefit	Risk		\$65	\$8 Generic	
				\$15 Brand	
United Health Plan of New England					
SeniorCare Direct	Risk	\$0			
SeniorCare Plus	Risk	\$60			
with drug benefit	Risk		\$133	\$10 All	
U.S. Healthcare					
Medicare Premier	Risk	\$20			
with drug benefit	Risk		\$59	\$10 All	
Medicare V	Risk	\$10			
with drug benefit	Risk		\$49	\$10 All	
Medicare X	Risk	\$0			
with drug benefit	Risk		\$39	\$10 All	

*Rate varies by geography

Hospital Copay	Office Visit Copay**	Emergency Room Copay♦	Outpatient Mental Health	Open Enrollment
\$0	\$2	\$0	\$2 per visit	Continuous
\$0	\$2	\$0	\$2 per visit	
\$0	\$5	\$25	\$5 per visit	Continuous
\$0	\$5	\$25	\$5 per visit	
\$0	\$5	\$25	\$5 (visits 1-8) \$35 (visits 9-20) 50% copay thereafter	Continuous
\$0	\$5	\$25		
\$0	\$5	\$25	\$5 (visits 1-7) \$30 (visits 8-20) 50% copay thereafter	Continuous
\$0	\$5	\$25		
\$0	\$5	\$30	\$0 (visits 1-7) to a maximum of \$500 in charges. 50% copay thereafter	Continuous
\$0	\$5	\$30		
\$0	\$5	\$20	\$10 per visit	Continuous
\$0	\$5	\$20	\$10 per visit	
				Continuous
\$100	\$10	\$35	\$10 (visits 1-20), 50% copay thereafter	
\$0	\$5	\$25	\$5 (visits 1-20), 50% copay thereafter	
\$0	\$5	\$25	\$5 (visits 1-20), 50% copay thereafter	
				Continuous
\$0	\$2	\$15	\$0 (visits 1-2), \$10 (visits 3-10), \$25 (visits 11+)	
\$0	\$2	\$15	\$0 (visits 1-2), \$10 (visits 3-10), \$25 (visits 11+)	
\$0	\$5	\$35	\$25 per visit	
\$0	\$5	\$35	\$25 per visit	
\$0	\$10	\$35	\$25 per visit	
\$0	\$10	\$35	\$25 per visit	

**For office visits with primary care physician. Some plans have higher copays for specialty care and home visits.

♦Copayment waived if admitted overnight to hospital

HMO	Vision Care	Hearing Care
Plan Name		
Fallon Community Health Plan		
Senior Saver	Exam: \$2 copay	Exam: \$2 copay
Senior Preferred	Eyeglasses: one pair standard lens and frame every 24 months	
HMO Blue		
Blue Care 65 - Value	Exam: \$5 copay	Exam: \$5 copay
Blue Care 65 - Value Plus	Eyeglasses: Up to \$100 every two years	Hearing aid allowance: \$400 every four years
As of 3/8/96, these plans are not available for sale.		
Harvard Community Health Plan		
First Seniority	Exam: \$5 copay	Exam: \$5 copay
with drug benefit	Eyeglasses: Up to \$100 every two years	Hearing aid allowance: \$500 every four years
Harvard Community Health Plan of New England		
Care Plus	Exam: \$5 copay	Exam: \$5 copay
with drug benefit		
Pilgrim Health Care		
Prime 65 - Option A	Exam: \$5 copay	Exam: \$5 copay
Prime 65 - Option B	Discount on eyeglasses Up to \$70 at Cambridge Eye	
Tufts Associated Health Plan		
Secure Horizons	Exam: \$5 copay	Exam: \$5 copay
with drug benefit	Eyeglasses: Up to \$69 per year	
United Health Plan of New England		
SeniorCare Direct	Exam only: \$10 copay	Exam only: \$10 copay
SeniorCare Plus	Exam: \$5 copay	Exam: \$5 copay
with drug benefit	One pair standard lens and frame per year	Hearing aid allowance: \$1000 every four years
U.S. Healthcare		
Medicare Premier	Exam: Same copay as office visit.	Hearing aid allowance:
with drug benefit	Prescription lens: Up to \$70 every 24 months	Up to \$500 every 36 months
Medicare V		
with drug benefit		
Medicare X		
with drug benefit		

Open Enrollment: All these HMOs offer continuous enrollment. If you meet the eligibility requirements, you can enroll anytime during the year.
For existing members changing from a plan without drug coverage to a plan with drug coverage within the same HMO - February and March

Additional Benefits	Address / Telephone	Service Area by Counties
Feeling Great Program: Two free classes per week at selected YMCA's. Health Education Programs	Fallon Community HP, Inc. 10 Chestnut Place Worcester, MA 01608 1-800-AT-FALLON	Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Worcester
Health Education Programs Nutrition Counseling Discounts at Fitness Centers Discounts on Exercise Equipment	HMO Blue 100 Summer Street Boston, MA 02110 1-800-678-2265	Statewide except: Dukes, Nantucket
Discounts at Fitness Centers Health Education Programs	Harvard Community HP 3 Allied Drive Dedham, MA 02026 1-800-779-7723	Bristol, Essex, Middlesex, Norfolk, Plymouth Suffolk, Worcester
Discounts at Fitness Centers Health Education Programs	Harvard Community HP of NE, Inc. 1 Hoppin Street Providence, RI 02903 1-800-835-5522 ext. 51406	Bristol, Middlesex, Norfolk, Plymouth, Worcester
Discounts at Fitness Centers Weight Watchers Discount Smoking Cessation Program	Pilgrim Health Care, Inc. 10 Accord Executive Drive Norwell, MA 02061 1-800-269-9302	Barnstable, Bristol, Essex, Middlesex, Norfolk, Suffolk, Plymouth, Worcester
At selected Fitness Centers: \$3 or \$5 charge per visit. Free membership/Diet Workshop with \$5 weekly copay	Tufts Associated Health Plan 333 Wyman Street Waltham, MA 02254 1-800-246-2400	Essex, Hampden, Norfolk Middlesex, Plymouth, Suffolk, Worcester
Preventive and Wellness Programs	United Health Plan of NE, Inc. 475 Kilvert St., Suite 310 Warwick, RI 02886-1392 1-800-448-4481	Bristol, Norfolk Worcester
Healthy Eating Program Healthy Breathing Program Partial Fitness Reimbursement: Up to \$150 every 6 months	U.S. Healthcare, Inc. 3 Burlington Woods Drive Burlington, MA 01803 1-800-991-9555	Barnstable, Bristol, Essex Hampden, Middlesex, Norfolk, Plymouth, Suffolk, Worcester
Note: Rates and service areas are subject to change. Contact HMO for updates.		



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QUESTIONS TO ASK WHEN EVALUATING AN HMO

To evaluate the quality of care you may receive from an HMO, ask the HMO the following questions, keeping in mind what features are most important to you.

Coverage: *All Medicare HMOs must provide coverage for all Medicare-covered services. The difference between plans is in the type of additional benefits being offered by the plan.* Does the HMO pay for physicals, hearing and vision tests, preventive services, or prescription drugs? What, if any, additional benefits? If the plan provides prescription drug coverage, does the plan have a mail order option?

Convenience: How far is it from the physician's office to my home? Does the plan have ample parking or is it near public transportation?

Cost: *When you join an HMO, you may pay a monthly premium, plus copayments for visits and prescription drugs.* What is the monthly premium? What are the copayment amounts for physician visits, mental health visits, ambulance and drugs? When was the last time the HMO premium increased? How much did it increase? How does this HMO's premium compare with another HMO with comparable coverage?

Quality issues: How does the plan evaluate its staff? How many doctors have geriatric training? How does the plan measure the satisfaction of its members? Is the plan accredited by the NCQA? What was the member disenrollment rate last year? How does the HMO handle complaints?

Choice: Is my current doctor or specialist a participating provider in the plan? What is the procedure for selecting or changing my doctor? Which hospitals, nursing homes, home health agencies, mental health practitioners and hospices does the HMO work with to deliver services?

Types of HMOs: *There are several types of HMO models that differ in how they are structured and where you can get covered services. Risk contract HMOs do not cover services that are received out of their network providers unless there was a need for urgent or emergency care. This is called a "lock-in" rule. Neither the HMO or Medicare would pay for unauthorized care received outside the network. With cost contract HMOs, if you receive covered services outside the network, Medicare will pay for its share but you will have to pay the deductibles and copayments you incur.* Does the HMO have a "lock-in" rule? How does the HMO define "urgent" and "emergency" care? What should I do in case of an emergency?

Access: How easy is it to get an appointment when you need it? What do I have to do in a medical emergency? What steps do I have to go through if my doctor decides I should see a specialist? Does the plan have bilingual staff? What hours of the day are staff available for questions? What are the hours for the druggist/pharmacy? Can I reach my physician by telephone?

Continuity: What percentage of doctors leave the plan each year? Will I be examined by my doctor or by the health care professionals on the staff? If my physician or specialist leaves the plan, will I be notified? If so, how much time will I have to select a new physician?

Coordination: If I see a primary care physician and several specialists, how will my care be coordinated among them so each is aware of my treatment needs and medications?

Flexibility: How can I get a second opinion? How can I switch to a new primary care physician or specialist? How can I challenge a decision if I disagree with the doctor or plan's decision?

WHERE TO GET MORE INFORMATION ABOUT HEALTH PLAN QUALITY

The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization that assesses and reports on health plan quality. NCQA provides information about health plan quality free-of-charge to consumers.

Call NCQA at 202/955-3515 to request a free-of-charge Accreditation Status List. The Accreditation List, updated each month, states which plans have full accreditation status with NCQA, which have pending accreditation decisions, and all plans who have scheduled a review.

Also, ask for a copy of the NCQA pamphlet titled, "Choosing Quality: Finding the Health Plan That's Right For You - A Guide for Consumers."

Beginning in July 1996, you can ask NCQA for a copy of the Accreditation Summary Report for any health plan they have reviewed since July

1995. These reports will detail how a plan performed in certain categories, such as giving plan members certain preventative treatments.

Contact the Member Services Department of the HMO for more information. Ask the HMO to send to you their marketing brochures which explain how the plan works and where its physicians are located.

In addition, ask the HMO if they hold informational meetings for people who are thinking about joining.

Ask the HMO if it has a "quality report card" and if the report card has been audited by NCQA or another outside organization. Ask them to send you a copy.

Ask for a copy of the HMO's member newsletter, health promotion literature, or annual report. This will show you how well the HMO communicates with its members.

Or, meet with a *SHINE Health Benefits Counselor* who can help you understand how the HMO works, what plans are available in your area, how to file a complaint when services are sub-par or when Medicare-covered services are denied.

The Serving Health Information Needs of Elders Program (SHINE) trains and certifies volunteer counselors to provide information, counseling, and assistance on health insurance options for senior citizens and Medicare beneficiaries.

To locate a SHINE Counselor in your community, call:

SHINE has an updated list of Medicare HMOs in Massachusetts as well as work sheets to help you compare your health insurance options.

K. MEDICARE HMO MEMBERSHIP

Advantages:

- *Quality of care is enhanced because of coordination of services
- *Easier to budget medical costs because premiums and copayments are fixed amounts
- *Other out-of-pocket expenses to enrollee are minimal and predictable
- *Less paperwork and no forms
- *Benefits beyond those covered by Medicare are available such as preventive and routine care
- *Health promotion and disease prevention
- *Twenty-four hour care

Possible Disadvantages:

- *Restriction on use of doctors, hospitals, and other health care providers
- *Must have prior approval to see a specialist, have surgery, or obtain other medical services
- *Enrollee may have to change from current physician
- *HMO facilities may not be easily accessible
- *Limitation on out-of-service area coverage
- *Ongoing treatment of chronic conditions may not be covered while outside the service area

HMO CONSUMER CHECKLIST

As a guide to elders in assessing and selecting an HMO, the following checklist suggests questions to ask of an HMO concerning convenience, cost, and quality.

CONVENIENCE ISSUES

- ☐ Where is the nearest HMO health center located?
- ☐ Where do HMO members receive medical care at?
 - ☐ Hospital(s)
 - ☐ Nursing Home(s)
 - ☐ Home Health Care Agencies
 - ☐ Physician Specialist(s)
- ☐ Where do HMO members get their prescription drugs?
- ☐ Does the HMO offer mail order prescription coverage?
- ☐ How is the conversion to the HMO from your current Medicare supplement handled?

COST ISSUES

- ☐ What will my HMO premium be?
- ☐ When was the last time the HMO premium changed? How much did it increase?
- ☐ Does the HMO require any copayments? If so, how much and for what services?
- ☐ How does the HMO premium compare to premiums of other plans with comparable coverage?

QUALITY ISSUES

- ☐ How many doctors practicing in the HMO serve elderly patients?
- ☐ What is the doctor turnover rate?
- ☐ Do the doctors make house calls?
- ☐ How many doctors are no longer accepting new patients?
- ☐ What is the procedure for selecting and changing physicians in the HMO?
- ☐ What is the average waiting time for an appointment?
- ☐ What is the HMO's patient disenrollment rate?
- ☐ How does the HMO handle complaints?
- ☐ What is the HMO's policy on patients receiving care outside its service area while they are traveling?
- ☐ What is the procedure for obtaining emergency care? Who makes the determination that it is an "emergency"?

USUAL BENEFITS OF HMO PLANS

(at minimum all services covered by Medicare plus more)

1. SERVICES

Office visits, including all medical and surgical care
Routine physical examinations
Consultations and care by specialists
Lab tests and X-rays
Surgical procedures performed in doctor's office
Mammograms (diagnostic and annual routine)
Allergy tests and injections
Change of removal of casts, sutures, and dressings
Routine immunizations (optional)
Radiation therapy
Physical, respiratory, and speech therapy
Dialysis services
Blood services
Chiropractic manual manipulation of the spine (x-ray not covered if
in chiropractor's office)
Endoscopic procedures, outpatient
Hearing tests and eye examinations (optional)
Allowance for hearing aids and eyeglasses (optional)

2. HOSPITAL

Unlimited medically necessary days for room and board in a
semiprivate room
Physician and surgeon services, including operations and specialist
consultations
Special care units, including ICU and Coronary Care Unit
Other hospital services, including operating room, recovery room,
anesthesia, X-ray, and laboratory services

Rehabilitation services
Cardiac, occupational, physical, and speech therapy
Radiation therapy

3. SKILLED NURSING FACILITY

Up to 100 days in each benefit period for a semiprivate room

4. EMERGENCY SERVICES

In the service area:

Emergencies are covered and do not require prior authorization;
small copayments may apply if not hospitalized overnight

Out of the service area:

Emergencies and urgently needed care are covered and do not
require prior authorization; small copayments may apply
Emergency ambulance transportation

5. SURGERY

Inpatient surgery

Outpatient surgery (in hospital outpatient facility)

Outpatient surgery (in doctor's office or ambulatory surgery facility)

6. PSYCHIATRIC CARE

Office visits

Inpatient psychiatric hospital care

Covered in full for a lifetime limit of 190 days combined.

Beyond the limit, the state mandates up to 60 days per calendar
year in a psychiatric hospital for mental conditions and up to 30

days per calendar year for inpatient substance abuse rehabilitation in a psychiatric hospital or substance abuse treatment center.

7. OTHER HEALTH SERVICES

Services of a home health care agency
Durable medical equipment and prosthetic devices
Ambulance services, when medically necessary
Home intravenous drug therapy
Ostomy supplies
Oxygen

8. PRESCRIPTION DRUG COVERAGE

All Medicare HMO plans available for sale in Massachusetts must offer two plans; one with and one without drug coverage. According to state law, the copayment amounts cannot exceed \$8 for generic drugs and \$15 for brand name drugs **OR** a copayment amount of up to \$10 for both generic and brand name drugs.

Some Medicare HMOs may have different copayment amounts depending on whether the drugs are purchased at one of their health centers or at a pharmacy, or based on the number of days for which the drug is prescribed.

At the discretion of the HMO plan, a mail order drug benefit may be offered. Same copayment maximums apply as described above.

9. DENTAL SERVICES

Dental services are optional. Benefits will vary from preventive cleanings and exams to more extensive coverage.

SERVICES AND SUPPLIES NOT USUALLY COVERED

- * COSMETIC SURGERY.
- * INJECTIONS THAT CAN BE SELF-ADMINISTERED.
- * PERSONAL OR COMFORT ITEMS DURING INPATIENT CARE (IE: TV, TELEPHONE.
- * HEARING AIDS OR DENTURES.
- * ORTHOPEDIC SHOES (UNLESS PART OF BRACE) OR FOOT SUPPORTS
- * ACUPUNCTURE.
- * HOMEMAKER AND DOMICILIARY CARE INCLUDING, BUT NOT LIMITED TO, LONG-TERM MENTAL HEALTH CARE.
- * PRIVATE-DUTY NURSING.
- * CARE FOR MILITARY SERVICE-CONNECTED DISABILITIES IN WHICH ENROLLEE IS LEGALLY ENTITLED TO SERVICES FROM OTHER AVAILABLE PROVIDER RESOURCES.
- * EXPERIMENTAL HEALTH CARE PROCEDURES.
- * SERVICES THAT ARE NOT REASONABLE OR NECESSARY FOR THE TREATMENT OF AN ILLNESS.
- * MENTAL HEALTH CARE OTHER THAN CRISIS INTERVENTION, SHORT-TERM THERAPY OR EVALUATION.
- * HOSPITALIZATION FOR REST CURES OR CONVALESCENCE IN NURSING HOMES.

HMO CHAPTER REVIEW

1. What is the name and telephone number of the HMO?

2. How much is the premium for this plan with prescription coverage?

3. Do I pay a co-pay for each prescription filled? _____
If yes, how much for Generic _____ Brand _____
4. If I go out of the network to receive Medicare covered services, will Medicare pay? Yes _____ No _____

Why? _____
5. Can I enroll in this HMO today? I have Medicare Part A & B, and I do not have ESRD. I am also not enrolled in a hospice program.
Yes _____ No _____
6. Does this HMO have any primary care physicians located in private practice offices? Yes _____ No _____
7. Who should I call if I need to see an allergist? _____
8. Will I have to pay any money out of my pocket to see my doctor?
Yes _____ No _____ If yes, how Much? _____
9. Can I send away for my prescriptions? Yes _____ No _____
If yes, how much will I pay for Generic _____ and Brand _____
10. My Medicare Part B is effective July 1, 1995, will I get a discount if I enroll on 9/22/95? Yes _____ No _____

PUBLIC BENEFITS AND MEDICAID

- TOPICS**
- . INTRODUCTION**
 - . SUPPLEMENTAL SECURITY INCOME**
 - . MEDICAID DEFINED**
 - . MEDICAID RECIPIENT CATEGORIES**
 - . REGULAR MEDICAID FOR AGED, BLIND AND
DISABLED**
 - . MEDICALLY NEEDY MEDICAID FOR AGED,
BLIND AND DISABLED**
 - . MEDICAID AND OTHER INSURANCE**
 - . MEDICAID FOR NURSING HOME RESIDENTS**
 - . SPOUSAL IMPOVERISHMENT PROTECTION**
 - . QUALIFIED MEDICARE BENEFICIARY (QMB)**
 - . SPECIFIED LOW-INCOME MEDICARE
BENEFICIARY**
 - . HOW TO APPLY AND DOCUMENTS NEEDED
TO APPLY**

INTRODUCTION TO PUBLIC BENEFITS

This Public Benefits chapter will present detailed eligibility criteria for several public benefits programs which offer Medicaid, or assistance with Medicare co-payments and deductibles. Each section provides eligibility criteria, application information, and examples of how to estimate a person's income. These income calculations are used to demonstrate how income levels are determined by agency staff.

As you counsel, you will need to ask a client if their income is above the Medicaid income level before you launch into Medigap counseling. If a client's income is near the Medicaid or SSI income levels, they may be interested in learning what Medicaid covers and how to apply.

Sometimes, the client may not feel comfortable discussing his/her exact income or asset levels. Nevertheless, you can still provide a valuable counseling service by telling your client about each program's benefits and how and where to apply if they are interested.

Also, you can provide valuable services to a client by explaining what documents are needed and where to get these documents, interpreting an application for them, and writing answers onto the application.

WHAT IS MEDICAID

The minimum benefit package under Medicaid must include:

- o inpatient hospital services,
- o outpatient hospital services,
- o physician services,
- o immunizations,
- o skilled nursing home care for adults,
- o home health care services,
- o laboratory and x-ray services,
- o health screening follow-up services for children under age 21,
- o family planning services,
- o rural health clinic services, and
- o transportation services for medical appointments. *

Massachusetts covers these additional services:

- o prescription drugs *
- o vision screening*
- o eyeglasses *
- o hearing aids *
- o adult day health attendance *
- o dental care*
- o intermediate nursing home care*
- o hospice

* These services are not covered under Medicare. So, a person who has **both Medicare and Medicaid** health insurance has more health care benefits than someone who is covered by Medicare only.

HOW COULD A PERSON WITH MEDICARE BENEFIT BY HAVING MEDICAID?

People who have both Medicare and Medicaid benefit in several ways. First, **Medicaid pays for all the Medicare premiums, deductibles and coinsurance amounts.** Second, **Medicaid provides coverage for services above and beyond Medicare's coverage,** namely prescription drugs, eyeglasses and hearing aids, dental care, medical transportation and attendance at adult day health centers.

ELIGIBILITY FACTORS: BASIC, CATEGORICAL AND FINANCIAL

First, a person who applies for Medicaid and SSI in Massachusetts must meet three **basic** eligibility criteria:

- they must be either a U.S. citizen or a lawful permanent resident alien.
- they must be a Massachusetts resident.
- and, they must have or file for a Social Security number.

Second, a person who applies for Medicaid or SSI in Massachusetts must satisfy one of three **categorical** requirements:

- be aged 65 or older, or
- be disabled, or
- be blind.

Lastly, a person who applies for Medicaid or SSI in Massachusetts must satisfy the **financial** eligibility requirements for the particular program.

- assets cannot be greater in value than the program's limits, and
- income from all sources must fall below the program's limits.

Some assets which are counted when valuing one's total assets include, but are not limited to:

- o Savings and Checking accounts
- o Life insurance policies
- o Second automobiles
- o Second homes or vacation property
- o Individual Retirement Accounts (IRA) accounts
- o Stocks and bonds

Assets which are NOT counted when valuing one's total assets for Medicaid include:

- o the home where one lives
- o one car
- o burial plots
- o irrevocable burial contracts
- o savings account/checking account no greater than \$2000 for a single person or \$3,000 for a married couple.
- o one's personal clothing and basic household furnishings.

A person's income is counted by adding together income from all sources, including wages and earnings, pensions, social security checks, and interest income.

Two Special Income Counting Rules:

First, remember to add back in the monthly Part B premium of \$42.50 to the Social Security pension check to get the total amount of the Social Security pension. The Part B premium is deducted from most pension checks before it is mailed.

Second, \$20.00 is almost always disregarded from each applicant's income, so subtract twenty dollars from all income to arrive at the total counted income amount.

EXAMPLE: Mr. Arvilla's monthly Social Security check is \$481.00. He has Part A and Part B coverage under Medicare. The premium for Part B is deducted from his total Social Security

pension. In fact, his total pension amount is \$523.50 ($\$481.00 + \$42.50 = \523.50) He has no other sources of income. Now, twenty dollars can be disregarded. So, his total counted income is \$503.50 ($523.50 - \$20.00 = \503.50)

The intake worker who processes the Medicaid application will be able to answer specific questions about each applicant's unique income situation.

WHERE SHOULD ONE APPLY TO GET MEDICAID?

People can get Medicaid from two programs: either the Supplemental Security Income Program, administered by the Social Security Administration, or from the Medicaid Program, administered by the Division of Medical Assistance.

The first agency to consider should be the Social Security Administration, which will consider the person's eligibility for the **Supplemental Security Income (SSI)** program. The SSI program provides a monthly cash supplement and medical coverage through the Medicaid program. (See SSI Section; below, for more details.)

The second agency to consider should be the Division of Medical Assistance (DMA). The staff at the MassHealth Enrollment Centers will accept applications (UNIV-1) and consider the person's eligibility for Medicaid. For example, if a person's application for SSI is officially rejected by the SSA, he/she can still apply directly for Medicaid. Sometimes, people prefer not to apply for SSI and to apply only for Medicaid.

Now, this Chapter will focus on the **benefits, eligibility criteria and application steps** for each of the public benefits programs with health care components.

SUPPLEMENTAL SECURITY INCOME (SSI)

In 1974, a federal **cash benefit** program called **Supplemental Security Income (SSI)** began. It replaced previously existing state welfare programs for the aged, blind and disabled. Its goal is to raise an **elder's income** to be even with a **minimum income level** (or **threshold**) and to provide related additional benefits.

All SSI recipients in Massachusetts also receive Medicaid and food stamps. Their SSI eligibility also establishes their eligibility for other financial assistance programs, including fuel assistance, utility discounts, free food distribution, weatherization services and many more. Refer your clients to the local Council on Aging or Agency on Aging Information Specialist for help in finding out about these other financial assistance programs.

To qualify for SSI benefits, a person must qualify under the categorical definitions for either **aged**, **blind** or **disabled**.

- a. An **aged** person must be **aged 65 or over**.
- b. A **blind** person must have central visual acuity of 20/200 or less in the better eye with the use of corrective lenses, or visual field restriction of 20 degrees or less.
- c. To be determined **disabled** under SSI, an individual must be unable to engage in substantial gainful employment because of a physical or mental impairment which has lasted or can be expected to last for 12 months or longer, or result in death.

SSI Eligibility Criteria: Income and Asset Guidelines

- a. To be eligible for SSI as an aged person, one must:
- (1) be a U.S. citizen, or lawful permanent resident, or an alien with a lawful claim to remain in the U.S., and
 - (2) be aged 65 or older, and
 - (3) have income within SSI guidelines, and
 - (4) have assets within SSI guidelines.

For aged individuals or couples who pay the **Full Cost of Living** expenses, the income and asset levels for 1996 are:

Income and Asset Levels for Supplemental Security Income (1996)

Full Cost of Living	Indiv.	Couple
Income	\$596.32/month	\$901.72/month
Assets	\$2,000.00	\$3,000.00

EXAMPLE: Mrs. Kingston is a 72 year old home owner who has lived alone for the past four years, since her husband dies. She has an eight year old automobile, \$1800.00 in the bank, a burial contract with the local funeral director for \$6,500, and old clothes and furnishings.

Her sole source of monthly income is her Social Security Check for \$495.00/month.

Add Part B	Disregard	Total Counted Income
\$495.00	\$537.50	\$517.50
<u>+ 42.50</u>	<u>-\$20.00</u>	Total SSI Monthly Supplement
\$537.50	\$517.50	\$78.82 (\$596.32 - \$517.50)

- a. SSI income and asset levels vary depending upon one's marital status and living situation. For other living arrangements under SSI payment guidelines, see pages 38-39 at the end of this chapter. Other income and asset levels apply for elders who share household expenses with someone other than their spouse, who pay less than their share of household expenses, or who live in a rest home.
- b. Some assets (e.g. a car, one's home) and some sources of income (some wages, for example) are not counted under SSI income calculations. Contact the Social Security Administration or refer to the "Guide to SSI for Groups and Organizations", pages 14-19, for more information.
- c. Apply for SSI by calling the Social Security Administration Office at **1-800-772-1213**. The intake worker will ask for basic information during this initial phone call. Then, the intake worker will instruct the caller on what documents will be needed to prove the answers on the application. These documents can be mailed in to the Social Security office or carried in hand to the intake worker.

If a person is eligible for SSI, then he or she is automatically eligible for Medicaid health insurance. All applicants can request **three (3) months of retroactive Medicaid coverage** to pay for medical bills incurred in the past 3 months. Retroactive Medicaid coverage must be applied for separately through the local Medicaid office.

Some people who are eligible for SSI do not want it. **They can apply for Medicaid health care coverage only**, apart from applying for the cash benefits of the SSI program, by applying at the local welfare office.

MEDICAID DEFINED

The federal-state Medicaid program was created in 1965 to assist the states in providing health care for the poor. States have considerable flexibility in structuring their program.

At the federal level, Medicaid is administered by the Health Care Financing Administration. At the state level, Medicaid is administered by the Division of Medical Assistance (DMA).

To apply for Medicaid, call the MassHealth Customer Service Center at 1-800-841-2900 or any of the MassHealth Enrollment Centers listed on page 10 and ask for an application (UNIV-1) to be mailed to the applicant or the SHINE counselor. Blind persons apply through the Massachusetts Commission for the Blind. Decisions on applications must be made within 45 days. If the applicant is applying as a disabled person, it may take up to 90 days for a decision. Coverage can be applied retroactively to medical bills accrued up to three months prior to application by making this request on the application.

SHINE counselors help **identify** persons who need Medicaid, but persons **must be referred** to the local welfare office to get an application. Once the application and verifying documents are complete, then the local welfare office will make the formal determination.

SHINE counselors should never "decide" whether a person is or is not eligible for any public benefits program. Leave that formal determination to the official agencies.

Medicaid recipients receive a health care card called a "MassHealth" card. Providers need to see this card to gain important claims information.

Medical services for Medicaid recipients may be obtained from any medical provider who accepts Medicaid. A patient must ask his/her doctors and providers of medical services if they accept Medicaid before receiving services. Providers are not required to accept Medicaid. Currently, a person aged 65 and older with Medicaid can see the doctors of their choice, as long as they receive care from a doctor or supplier who accepts Medicaid.

- a. **People under the age of 65** who are enrolled in Medicaid due to blindness, a disability, or other categories and do not have any other health insurance are enrolled into a managed care system. A recipient must choose either a primary care clinician with Medicaid or enroll in a Medicaid HMO plan. The primary care physician/clinician must give prior approval for the patient to seek specialty services. For client information, call the MassHealth Customer Service Center at 1-800-841-2900.

MassHealth Enrollment Centers

Charlestown

The Schraffts Center
529 Main Street
Charlestown, MA 02129

800-662-9996
(617) 248-4200
TTY: 800-608-3300
(617) 248-4335 (Fax)

Springfield

311 State Street
Springfield, MA 01105

800-332-5545 or 800-321-2007
(413) 785-4100
TTY: 800-596-1276
(413) 785-4180 (Fax)

Taunton

21-A Spring Street
Taunton, MA 02780-0711

800-242-1340 or 800-823-7897
(508) 828-4600
TTY: 800-586-1272
(508) 828-4611 (Fax)

MEDICAID PROGRAMS

Medicaid programs vary due to the age and family structure of the recipients. The Medicaid programs related to aged persons (age 65 and older) are:

- a. Regular Medicaid for the Aged, Blind and Disabled.
- b. Medically Needy Medicaid for the Aged, Blind and Disabled
- c. Medicaid for the Nursing Home Resident, including Spousal Impoverishment Protection rules.
- d. Qualified Medicare Beneficiary Program, and the
- e. Specified Low-Income Medicare Beneficiary Program

COMMUNITY MEDICAID PROGRAMS: "REGULAR" MEDICAID PROGRAM AND THE "MEDICALLY NEEDED" MEDICAID PROGRAM

For an elder living in the community to be eligible for Medicaid, the elder must be:

- a. aged 65 or older,
- b. have a low monthly income, and
- c. a limited amount of assets.
- d. Once a person attains a permanent residency status according to the rules of immigration in the United States, then they have satisfied the residency requirement for Medicaid.

The **Regular Medicaid** and the **Medically Needy Medicaid** programs use different income and asset rules to determine eligibility for individuals and couples.

Regular Medicaid recipients cannot have their total income and assets higher than the limits printed in the box below. They must verify these figures by submitting documents at the time of application. If the applicants monthly income and resources are below these levels, then they will be permanently eligible as long as their income and assets remain below these levels.

Maximum Income and Asset Levels for Regular Medicaid (1996)

	Individual	Couple
Income (Federal Poverty Level)	\$665/mo.	\$884/mo.
Assets	\$2,000.00	\$3,000.00

To qualify for the Regular Medicaid Standard, one's total income must be no higher than this income standard. So, if one's income is a mere \$1.00 above this income standard, he or she would not be eligible for Regular Medicaid, but they could still apply for medical coverage under the "**Medically Needy Medicaid Program**". They would have to spend their "excess" income on medical expenses and lower their income level, after medical expenses, to the much lower income levels required in the "**Medically Needy Medicaid**" program, shown in the box (on the next page).

Income and Asset Levels for Medically Needy Medicaid (1996)

	Indiv.	Couple
Income	\$522/month	\$650/month
Assets	\$2,000.00	\$3,000.00

If the applicant's income is over the Regular Medicaid income limits, he or she may be eligible for "**Medically Needy**" Medicaid coverage on a delayed basis, after spending down their excess income.

To qualify, the recipient must incur medically related bills equal to the amount his/her income exceeds the Medically Needy Medicaid income levels. Then Medicaid coverage will begin and last for the balance of the six month period. This excess amount is called "the deductible" or "the spend down amount". The process is often referred to as "meeting the spend down".

Once someone becomes enrolled in this program, then their future medical costs would be paid for until the end of a six-month period.

Every 6 months, the recipient must go through a new spend-down period to re-qualify for the "**Medically Needy Medicaid**" program.

SUMMARY AND EXAMPLE: If one's income is over the "Regular Medicaid" income levels (of \$665 for an individual or \$884 for a couple), then to qualify for the Medically Needy Medicaid Standard, one must undergo the spend-down process outlined below and on the work sheet presented on page 16.

STEP 1: Calculate total monthly income; remember to add back the \$42.50/month Medicare Part B premium (1996) to their Social Security check, if it is deducted monthly.

STEP 2: Check to see if the gross income falls below the Regular Medicaid levels of \$665 or \$884.

STEP 3: The spend down formula disregards \$20.00 of any earned or unearned income. Note, couples receive only a \$20.00 disregard on most income, the same amount as for individuals.

STEP 4: Then, calculate the monthly income in excess of the Medically Needy Medicaid Income levels of \$522 for an individual or \$650 for a married couple.

STEP 5: Then multiply the monthly excess income by 6 to determine the 6-month spend-down amount.

STEP 6: Now deduct any receipted medical expenses from the applicant's six-month excess income spend-down amount, including but not limited to the following items:

(a) The Medicare Part B Premium can be deducted for the full six month period

$$(42.50 \times 6 = \$255.00 [1996])$$

- (b) Health insurance premiums, e.g. Medicare supplement insurance premiums can be deducted for the full six month period.

Medigap policy at \$98/month x 6 = 598.00.

- (c) Any medical bills the person still owes for necessary medical treatment, regardless of how old the date on the bill is, if the provider will certify that the bill is still owed and due. (Some providers close out their books and write off some debts.) Ask the provider to re-issue a billing statement.
- (d) Diapers for incontinent adults
- (e) Non-prescription over the counter (OTC) drugs, such as aspirin, vitamins, etc. The cashier at the drug store should identify the product on the sales receipt and initial the receipt.
- (f) Transportation to medical appointments via any means
- (g) Participation in an Adult Foster Care Program
- (h) Costs of attending an adult day health care program.

Special notes on MA spend-down deductions:

- (a) Long term care insurance premiums are not counted in the spend-down calculation.
- (b) Some medical costs considered for spend-down are not covered services under the Medicaid program once a person is enrolled. However, they are medical expenses used for reaching eligibility through the

spend-down process. Some examples are the OTC drugs and diapers for incontinent adults.

A SPEND-DOWN PROCESS EXAMPLE: Mr. Armondo applied for Medicaid on October 1, 1996 and had only \$1000.00 in assets but too much income for Regular Medicaid. This is how the spend-down amount would be figured and how his medical expenses for the next six months would be counted and applied to meet his spend-down.

STEP 1: Calculate total monthly income; remember to add back the \$42.50/month Medicare Part B premium (1996) to their Social Security check, if it is deducted monthly.

Social Security	\$595.00
Part B Premium	<u>42.50</u>
	\$637.50
Teacher Pension	<u>40.00</u>
Total Income	\$677.50

STEP 2: Check to see if the income falls below the Regular Medicaid levels of \$665 or \$884.

$$\$677.50 > \$665.00$$

STEP 3: The spend down formula disregards \$20.00 of any earned or unearned income. Note, couples receive only a \$20.00 disregard on most income, the same disregard amount as for individuals.

$$\begin{array}{r} \$677.50 \\ - \quad 20.00 \\ \hline \$657.50 \end{array}$$

STEP 4: Then, calculate the monthly income in excess of the Medically Needy Medicaid Income levels of \$522 for an individual or \$650 for a married couple.

Excess Monthly Income	\$657.50
-	<u>522.00</u>
	\$135.50

STEP 5: Then multiply the monthly excess income by 6 to determine the 6-month spend-down amount.

$$\$135.50 \times 6 = \$813.00 = \text{SPEND DOWN AMOUNT}$$

STEP 6: Now deduct any receipted medical expenses from the applicant's six-month excess income spend-down amount, including but not limited to the following items:

Core Medigap Premium	\$33/month x 6 months = \$198
Part B Premium	\$42.50/month x 6 months = \$255

$\$813.00 - \$198 - \$255 = \360 - **THIS AMOUNT STILL MUST BE SPENT BEFORE MEDICAID WILL PAY FOR FUTURE MEDICAL EXPENSES.**

Prescription Drugs paid for between October 1-30 = \$350.00
 Taxi to City Hospital, October 28th = \$10.00

$\$360 - 350 - 10 = 0$ The spend down deductible has been met as of October 30, 1996.

If a person needs help to meet a spend-down of excess income or to convert excess assets into non-countable assets, then ask their Medicaid case worker for assistance. They can explain the spend-down process and show how to set aside extra assets so that a person can become income and asset eligible for Medicaid.

MEDICAID AND OTHER INSURANCE

Medicaid is always the payor of last resort. So, any other insurance plan, including Medicare or employer-based health plans, must pay first before Medicaid will pay.

- a. Remind the Medicaid recipient to identify the names and policy numbers for any other insurer whenever they file a claim. Medicaid is always the payor of last resort.

Often, a new Medicaid recipient will also have a Medigap policy and they will not know if they should keep the Medigap policy. Their income may be so limited that it is nearly impossible to keep paying for a private insurance policy.

However, a recipient may want to keep his/her Medicare supplement health plan if he/she will be only temporarily enrolled in Medicaid, as in the case of a Medically Needy Medicaid recipient. Some people have excessive health care costs for only a brief time because they have had a health care emergency such as an automobile accident or a stroke. Perhaps they need Medicaid to pay only for the short term therapy and rehabilitation costs. For other people, the expense of a private policy may be worth it if it provides greater coverage than Medicaid. If either situation occurs, the client may not want to suspend their private policy while Medicaid is in effect.

Generally, people who are enrolled in the **Regular** Medicaid Category probably have a **fixed and limited** income; it will never grow higher than the level required for Medicaid eligibility. For these persons, a separate Medicare Supplement plan may be an unnecessary expense because Medicaid provides very comprehensive coverage. If this situation occurs, the client may want to either suspend or cancel their Medicare Supplement plan. Work closely with your SHINE Coordinator in this situation.

Medicaid recipients with a Medicare supplement policy can suspend their Medigap policy for up to 24 months without penalty or disadvantage.

- a. The suspension must be initiated by the Medicaid recipient within 90 days of becoming enrolled in Medicaid.
- b. During the suspension period, which can last up to 24 months, the Medicare Supplement insurer does not charge any premiums against the policyholder and the insurer provides no benefits.
- c. Subsequently, if the person is no longer eligible for Medicaid, the Medigap insurer must reinstate the policy coverage, effective as of the date of termination of Medicaid eligibility.
- d. The policyholder must notify the insurer when his or her Medicaid eligibility ends in order to reinstate active coverage.
- e. Any insurer who violates these requirements is subject to a stiff civil penalties (fine).

MEDICAID FOR NURSING HOME RESIDENTS

Eligibility regulations for persons in nursing homes are completely different from those applying to persons residing in the community.

Prior to entering into a nursing home, an individual must go through two application steps.

First, he/she must undergo a medical pre-admission nursing home screen. Medicaid only pays for nursing home services if other less restrictive community-based alternatives would not be adequate to keep the elder safely residing in the community. The medical screens are performed by nurses from the local Home Care Corporation's Coordination of Care unit.
Tel: _____

Second, a person should complete a Long Term Care Medicaid application (MA/LTC-1) and mail it to any of the three MassHealth Enrollment Centers (MEC) listed on page 10. The MEC will provide the technical assistance necessary to complete the application and the verification steps.

Taunton	1-800-242-1340
Charlestown	1-800-322-1448
Springfield	1-800-332-5545

The nursing home resident must apply almost all their income to pay for the cost of nursing facility care. However, the resident may keep:

- (1) \$65.00 per month for his/her monthly Personal Needs Allowance (PNA),
- (2) some money to pay their medical insurance premiums, and
- (3) some money can be given to the spouse who lives at home in the

community, if he/she needs this money to make up their Minimum Maintenance Needs Allowance allotted to him/her.

- (4) other limited allowances to maintain one's primary residence and to support dependent children.

A nursing home resident cannot retain assets with a value greater than \$2,000.00. Some savings accounts and burial contracts are not counted when counting total asset values. Also, the nursing home resident's primary residence is not counted in some circumstances. Examples of counted assets include bank accounts, Certificates of Deposit (CDs), stocks, annuities, etc.

Medicaid pays the nursing home the difference between the patient private paid amount (the patient's ability to pay) and the established rate of the facility.

Any questions about the Medicaid's right to try to recover money from an estate of someone who received Medical Assistance should be directed to the Long Term Care Eligibility offices of Medicaid.

SPOUSAL IMPOVERISHMENT PROTECTION RULES UNDER MEDICAID WHEN ONE MEMBER OF A MARRIED COUPLE ENTERS A NURSING HOME AND APPLIES FOR MEDICAID

Spousal protection rules apply to the nursing home resident's spouse who lives at home in the community. The purpose of the law, enacted in 1988, was to stop the impoverishment of the community spouse, usually the wife, which resulted when the nursing home spouse had to apply all his income to the nursing home bill. The reform measures allow the spouse at home to keep more in assets and a greater share of their combined incomes in order to prevent her becoming financially impoverished.

- a. The community spouse will be promised a certain monthly income amount, called a "**Minimum Maintenance Needs Allowance**". In 1996, this allowance will not be less than \$1,254.00 (150% Federal Poverty Level) and not more than \$1,919.00.

The community spouse's **actual shelter costs** are part of the **calculation** for the monthly allowance. The nursing home resident must give part of his income to the spouse at home to make up the difference between her own personal income and the total Monthly Maintenance Needs Allowance. The calculations for determining the allowance can be appealed.

- b. All assets are divided equally between husband and wife regardless of whose name is on the title or deed.

In 1996, the community spouse is protected in that her share would not be less than one-half of all assets, or \$15,348.00, whichever is higher.

EXAMPLE: If couple has combined assets of \$100,000. Each spouse would get \$50,000 from the initial division of assets.

EXAMPLE: Couple has combined assets of \$20,000. Each person would not get one-half. Instead, community spouse would get at least the minimum amount of \$15,348 and institutionalized spouse would get \$4,652 from the initial division of assets.

However, her one-half share cannot exceed \$76,740.00 (1996).

EXAMPLE: If couple has combined assets of \$200,000. community spouse would get \$76,740 and the institutionalized spouse would get \$123,260 from the initial asset division.

The community spouse can appeal the initial division of assets and make a special argument that he/she needs to retain a larger share of the assets in order to earn income as part of her minimum maintenance needs allowance. They should consult with an attorney to learn more about this option.

- c. Transferring assets defined as either income and resources within 30-36 months (depending upon the date of the transfer) before either the application or admission to the nursing home, whichever date is later, may cause a Medicaid applicant to be ineligible for a period of time. (An even longer look back period of 60 months may now apply to transfers related to some trusts.)

The 36-month look back period will apply to all applications submitted on or after August 1, 1996. Prior to August 1996, the 30-month look back period will apply. Certain trusts will have a 60-month look back period for all applications submitted on or after August 1, 1993.

- d. If people give away valuable assets and then apply for Medicaid, they could be disqualified from Medicaid eligibility for several months or years. To determine how many months a person could be disqualified, the value of any asset given as a gift (for less than fair market value) is divided by the average cost for a month's stay in a nursing home (\$4,500.00) (1996). These months of disqualification begin as of the date of the transfer of the asset.

For advice on asset transfers and Medicaid estate planning, refer all **SHINE** clients to an elder law attorney of a local Legal Services office, the Long Term Care Medicaid offices, a private attorney, or the Massachusetts Bar Referral Service (1-800-392-6164). Only attorneys or staff of the Medicaid Long Term Care Eligibility offices can counsel on up-to-date Medicaid estate planning options.

Our purpose in giving you this information is to prepare you so that you can inform community spouses that they may not become as financially impoverished as they had feared if their spouse were to need nursing home care. Many people do not know about these new rules which aim to prevent the community spouse from falling into poverty after her spouse moves into a nursing home!

QUALIFIED MEDICARE BENEFICIARY (QMB) PROGRAM

The QMB program pays all of Medicare's premiums, deductibles and coinsurance amounts for certain elderly and disabled persons who are entitled to Medicare Part A, whose annual income is at or below the national poverty level, and whose savings and other resources are very limited. The QMB program, thus, functions like a Medigap policy and more because it also pays the Part B premium.

The Qualified Medicare Beneficiary has no "spend-down". It is purely a pass or fail income and asset based eligibility process. These income and asset limits are:

Maximum Income and Asset Levels for Qualified Medicare Beneficiary Program (1996)

	Indiv.	Couple
Income	\$665/month	\$884/month
Assets	\$4,000.00	\$6,000.00

The Qualified Medicare Beneficiary (QMB) program is a special Medicaid program which can benefit low-income Medicare beneficiaries in several ways.

- o The QMB program is a useful program for a low-income Medicare beneficiary who has too many assets for Medicaid but not too many for QMB, and cannot afford a private Medicare supplement insurance.
- o Second, the QMB program is useful for low-income elders who are not eligible for Medicare premium-free because they have not worked enough Social Security quarters to be

eligible for a Social Security pension.

Apply for the QMB program by mail or in person at any of the MassHealth Enrollment Centers listed on page 10. To receive an application (UNIV-1), call the MassHealth Customer Service Center at 1-800-841-2900.

The Medicaid staff have 45 days to find the applicant eligible or ineligible. It may take longer. If the client experiences a delay beyond the 45 days, they should call the MassHealth Enrollment Center where they filed the application to check on the status.

The Qualified Medicare Beneficiary program benefits are **not retroactive**; they become effective at the beginning of the first calendar month after the month of determining eligibility.

JANUARY	FEB	MARCH	APRIL	MAY	JUNE
Month of application		Month of decision (up to 45 days allowed)	Earliest month of benefit coverage		

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB) PROGRAM

Persons who have an income higher than the QMB program limits, but whose assets still qualify, may be eligible for the Specified Low-Income Medicare Beneficiary program.

Specified Low-Income Medicare Beneficiaries only have one Medicare expense paid for through the state Medicaid program:

- a. **the Medicare Part B premium.**

The SLMB program is for persons entitled to Medicare Part A and whose incomes are slightly higher than the national poverty level. The income cannot exceed the national poverty level by more than 20 percent.

Like the QMB program, the Specified Low-Income Medicare Beneficiary program has no spend-down process.

Maximum Income and Asset Levels for Specified Low-Income Medicare Beneficiary Program (1996)

	Individual	Couple
Income On or Below	\$794/mo.	\$1056/mo.
Assets	\$4,000.00	\$6,000.00

Apply for the SLMB program by mail or in person at any of the three MassHealth Enrollment Centers. To receive an application (UNIV-!) call the MassHealth Customer Service Center at 1-800-841-2900 or call the MassHealth Enrollment Centers listed on page 10. The DMA has 45 days to process the claim.

The Specified Low-Income Medicare Beneficiary program **benefits are retroactive for up to three months.** They become effective as of the month of approval or up to three months prior to the month of application.

OCT.	NOV.	DEC.	JAN.	FEB.	MARCH
Earliest possible month of benefit coverage			Month of application		

How to Apply for SSI, QMB, SLMB or Medicaid Programs

People can get Medicaid from two programs: either the Supplemental Security Income Program or the Medicaid Program.

The first agency to consider should be the Social Security Administration, who will consider the person's eligibility for **Supplemental Security Income**. If they are accepted, then they will get a monthly check for income assistance and automatic enrollment into Medicaid, too.

If a person's application for SSI is officially rejected by the SSA, then they can apply directly to the MassHealth Enrollment Centers for **Medicaid** only.

To apply for SSI, a person can call the Social Security Administration and start the application process over the phone. Tel: 1-800-772-1213 [or 1-800-325-0778 (Telephone Device for the Deaf)] The application form is begun by the SSA intake worker. Then, the worker identifies all the official documents needed to verify the eligibility criteria written on the application.

The applicant can mail or bring the documents needed for verification in person to the local SSA office in order to complete the application. A decision should be made within 13 days after the application is completed.

Apply for SSI as soon as possible to avoid losing benefits. The first date you contact the Social Security Administration (SSA) is the earliest date from which benefits can be paid.

Someone else can call for an applicant; either the applicant or his/her representative can sign the application.

If someone needs an interpreter, they may bring a translator or

interpreter with them for the interview, or, they may ask the SSA to find someone to translate or interpret for them.

REMEMBER: The earliest possible date from which SSI benefits may begin is the very first day the applicant contacts the Social Security Administration and tells them of their intent to apply. This is called the "protective filing date."

Encourage your clients to apply as early as possible to get the best protective filing date!! Verification documents can be collected and submitted after the initial contact has taken place.

To apply for Medicaid, QMB or SLMB, get an application (Form UNIV-1) by calling the MassHealth Customer Service Center at 1-800-841-2900 or any of the three MassHealth Enrollment Centers listed below. Ask for an application to be sent either to the applicant or to the SHINE Counselor.

MassHealth Enrollment Centers

Charlestown

The Schraffts Center
529 Main Street
Charlestown, MA 02129

800-662-9996
(617) 248-4200
TTY: 800-608-3300
(617) 248-4335 (Fax)

Springfield

311 State Street
Springfield, MA 01105

800-332-5545 or 800-321-2007
(413) 785-4100
TTY: 800-596-1276
(413) 785-4180 (Fax)

Taunton

21-A Spring Street
Taunton, MA 02780-0711

800-242-1340 or 800-823-7897
(508) 828-4600
TTY: 800-586-1272
(508) 828-4611 (Fax)

A person must complete the Medicaid application (UNIV-1) and mail it to the MEC. Then the applicant must provide documents to prove the statements on the application. The applicant will receive a letter indicating what documents are needed.

A decision should be made within 45 days. Coverage can be applied to bills incurred up to three months before the date of application.

There is also a MassHealth Enrollment Center in Tewksbury that will assist clients who wish to walk-in and submit an application. Walk-ins are welcome at all the MassHealth Enrollment Centers.

MassHealth Enrollment Center in Tewksbury

367 East Main St.

Tewksbury, MA 01876-1957

800-408-1253

508-262-9100

508-262-9212 (Fax)

800-231-5698 TTY

Apply for Long Term Care Medicaid at any of the three MassHealth Enrollment Centers listed on page 30. Call the MassHealth Customer Service Center at 1-800-841-2900 or any of the MassHealth Enrollment Centers to ask for an application (MA/LTC-1) to be sent or to get technical assistance on completing the application.

A person should file an application **as soon as possible after the initial date of institutionalization** because this is the date a "snapshot" is taken of their financial affairs. If they know in advance their need for nursing home care, then they may begin the process when they decide to move into a LTC facility.

If one is already on SSI or MA, then no new application is needed. A smaller questionnaire is sent for information about a few assets. Medicaid doesn't pay for rest homes; only SSI or EAEDC pay for rest home board.

The Two Application Steps for Long Term Care Medicaid: Financial Eligibility and Medical Eligibility Determinations

Financial Criteria

Forms: Social workers in hospitals and nursing homes have Long Term Care Medicaid applications and they often help to complete the application.

If counseling a community-based client who intends to move from the community directly into a LTC facility, then contact any of the MassHealth Enrollment Centers and request the application to be mailed to the client's home or to your office. Once it arrives, contact the client and arrange for a meeting to fill out the application and to begin gathering the verification documents.

Medical Criteria

Contact the local Home Care Corporation and ask for a pre-admission nursing home screen. The medical screen will be performed by a nurse of the Coordination of Care unit of the local home care corporation.

The nurse must determine whether or not the person is medically eligible under Medicaid's standards before Medicaid will help to pay the cost of the person's stay in a LTC facility.

How to Complete the Application

Every question must be answered with a YES, NO or N/A placed in each blank space.

The application must be signed in order to be complete. Faxed signatures cannot be accepted; it must be the original signature page.

Verifications

Submit verifications in a timely manner. After filing the application, the applicant has 30 days to submit all supporting verification documents. Only one additional set of 15 days will be given to finish gathering all verifications. If these 45 days (30 + 15) pass before all documents have been submitted, then the original application date and month will be lost. Hereafter, 30 additional days are given in which the verification documents can still be submitted and the full application approved. However, the month for completing the application is now the new, later month.

Medicaid Coverage for People Returning Home Again

If a person moves home from the LTC facility, then their Medicaid case will move to the community Medicaid office. The eligibility criteria will be reviewed. Often, the recipient will lose their Medicaid status because their available income is greater than the Medicaid level for eligibility.

Social Security Numbers (SSN)

The applicant must have a SSN or apply for one. Medicaid will not delay or deny the Medicaid eligibility determination while the applicant is obtaining the SSN. Contact the Social Security Administration to get the number.

It is alright if you do not have all these documents when you apply!
The intake case worker will tell you what they need you to get to complete the application.

The Social Security Administration requires that original documents be used to verify information written on the applications; the Medicaid office will accept copies. Also, documents should be less than 45 days old, or else newer documents may be requested of the applicant.

SSI Benefits: Income Supplements For Varying Living Situations

An SSI recipient receives a cash supplement to raise their total monthly income to the minimum SSI income level in their State. The federal government sets a national SSI minimum income level for aged persons; states are allowed to add additional income for their citizens.

The Commonwealth of Massachusetts adds additional income to each of the federal income levels that apply to different living arrangements for aged persons. These living arrangements are defined, below, and then the minimum income levels for Massachusetts elders are printed in the chart, below.

Definitions of SSI Living Arrangements -

Categories A, B,C, E, and F

A = FULL COST OF LIVING - Means paying 2/3 or more of full household expenses.

B = SHARED LIVING EXPENSES - Means paying within \$5.00 of one's pro-rated share (equally divided share) of rent, food, heat, etc.

C = HOUSEHOLD OF ANOTHER - Means making only token (less than full value for one's share of room and board) cash contributions to the household.

E = REST HOME - Means residing in a licensed rest home; resident pays all income toward board and care expenses of the rest home except for retaining a Personal Needs Allowance of \$65.00/month.

F = MEDICAID FACILITY - Residing in a facility (i.e. Medicaid approved nursing home) in which Medicaid pays over 50% of the cost of care for that month.

SSI Living Arrangements	Target Income Level (1996)	Target Income Level (1996)
	Single Person	Married Couple
A. Full Cost of Living	\$596.32 / month	\$901.72/ month
B. Shared Living	\$506.76 / month	\$901.72 / month
C. Household of Another	\$415.20 / month	\$680.80 / month
E. Rest Home	\$763.00 /month	\$763 per person per month
F. Medicaid Facility	\$65.00 / month	\$65.00 per person per month

There is no category "D".

An applicant's actual incomes may exceed these targets, but the applicant can still qualify because some income deductions are permitted. Even aged persons who are working may qualify for SSI because of income deductions applied to their earned wages!!

For all applicants, the \$20.00 "disregard" is applied to all applicant's income: in effect, the public benefits agency does not count \$20.00 when totalling all income sources.

If any client's income is close to these targets, strongly urge them to consider applying; never "determine" their eligibility status. Only the Social Security Administration can do that!

CLASS EXAMPLE: a 68 year old single woman who lives alone applies for SSI. Her only source of income is her Social Security check for \$480.00 /month. The Part B premium of \$42.50 is deducted from her payment before she receives the check.

QUESTIONS:

- 1 What benefits would she get if she applies for SSI?
- 2 How would her financial situation improve?

CLASS EXAMPLE: ANSWER

Total Income

$$\begin{array}{rcl} & \$480.00 & \\ + & \$42.50 & \\ \hline & = \$522.50 & \\ - & \$20.00 & \text{disregard} \\ \hline & = \$502.50 & \text{SSI counts this as her total monthly income.} \end{array}$$

SSI would pay a monthly check to her for \$93.82 to raise her income to the SSI threshold of \$596.32. ($\$596.32 - \$502.50 = \93.82)

She would also receive food stamps and Medicaid. Medicaid would pay for her Part B premium of \$42.50 per month.

If she was paying for any Medicare Supplement policy, she could suspend it or cancel it and save that money too.

She could apply for fuel assistance to receive some help paying for winter fuel bills.

She would have established her eligibility for other financial assistance programs which could save her even more money.

Medicaid / QMB / SLMB / SSI Worksheet for 1996
for use in the SHINE Program

Only For Adults Aged 65 and Over Who Reside in Their Own Household

(Different Standards Apply for Disabled Adults and Adults Sharing Household Expenses or Residing in Another's Household, a Rest Home or a Medicaid Facility)

Name: _____ DOB: _____

The person must be 65 years of age to be eligible for Medicaid or SSI, unless they are disabled. A person must be Medicare-eligible, through age or disability, to be eligible for QMB and SLMB.

Monthly Income:

All sources of Monthly Income: \$ _____
(Social Security, Pension, Annuities, Interest, etc.)

Assets:

Total amount in Checking/Savings Account: \$ _____
(plus bonds, stocks, but not including car or home)

(All income levels on this checklist contain \$20.00 above the actual income level because the programs usually disregard \$20.00 of income to determine eligibility.)

1. To qualify for Medicaid: Monthly Income Limits

	Indiv.	Couple
A. Regular Community Income Std (100% of Fed. Pov. Std.)	\$665	\$884
Assets	\$2000.00	\$3000.00

**Medicaid / QMB / SLMB / SSI Worksheet for 1996
for use in the SHINE Program**

- Page 2 -

An applicant whose income is higher than the income limits may become eligible for Medicaid by spending down excess income. The person has to incur medically related bills that equal or exceed his/her excess income within a six month time period.

		<u>Monthly Income Target Level</u>	
		Indiv.	Couple
B.	Medically Needy Income (Spend Down Target)	\$542	\$670
	Assets	\$2000.00	\$3000.00

2. To qualify for Qualified Medicare Beneficiary Program (QMB):

		<u>Monthly Income Limits</u>	
		Indiv.	Couple
	Monthly Income Standard 100% Fed. Pov. + \$20	\$665	\$884
	Assets	\$4000.00	\$6000.00

3. To qualify for the Specified Low-Income Medicare Beneficiary Program (SLMB):

		<u>Monthly Income Limits</u>	
		Indiv.	Couple
	Monthly Income Standard 120% Fed. Pov. + \$20	\$794	\$1056
	Assets	\$4000.00	\$6000.00

4. To qualify for the Supplemental Security Income Program (SSI):

	<u>Monthly Income Limits</u>	
	Indiv.	Couple
Monthly Income Std. Full Cost of Living Group*	\$616.32	\$921.72
Assets	\$2000.00	\$3000.00

- * The SSI Program uses different Income Limits for disabled adults and adults who are sharing household expenses or are living in another`s household, or living in a rest home or Medicaid facility.

PUBLIC BENEFITS CHAPTER EXERCISES

1. What do the letters SSI stand for?

2. What agency handles SSI applications?

3. From what date are SSI benefits paid? (Circle One)
 - a. Date of Completing application.
 - b. 1st month after applying
 - c. Initial Inquiry Date
4. A homeowner can never receive SSI. True_____ False_____
5. If a spouse enters a nursing home for a long term stay, then he/she must apply all of his/her income towards the nursing home bill. True_____ or False_____.
6. If a single woman moves into a nursing home for a long term stay, she must sell her home. True_____ or False_____.
7. For an applicant for Long Term Care Medicaid, how many days are permitted for submitting all verifications?
15 days_____ 30 days_____ 45 days_____ 60 days_____

8. For QMB beneficiaries, which out-of-pocket-costs associated with the Medicare program are paid for by Medicaid?

9. Which income level is closest to the 1996 Federal Poverty Level for an individual? (Choose One)
\$581 \$601 \$623 \$634

10. Name at least four benefits which are not covered by Medicare but are covered under Medicaid.

a. _____

b. _____

c. _____

d. _____

11. If a client of yours became very uncomfortable talking about their personal income and assets, how would you counsel them?

PROGRAMS TO ASSIST MASSACHUSETTS RESIDENTS
SERVING HEALTH INFORMATION NEEDS OF ELDERS

PROGRAM	1996 LEVEL	OTHER
Medicare	Patient Pays	Effective Date
Hospital Deductible - Part A	\$736 per benefit period	
Hospital Copayment - Part A		
Days 61-90	\$184 per day	1-1-96
Days 91-150 (lifetime reserve days)	\$368 per day	
SNF Copayment - Part A		
Days 21-100	\$92 per day	1-1-96
Part B Deductible	\$100/year	1-1-96
Part B Premium	\$42.50/month	1-1-96
Part A Premium (if not free)		
- 30 to 39 quarters of covered employment	\$188/month	1/1/96
- Less than 30 quarters	\$289/month	
Medical Assistance Programs	Maximum Monthly Income	Maximum Assets
Medicaid	\$665 - indiv.	\$2,000
Federal Poverty Level plus \$20 disregard	\$884 - couple	\$3,000
QMB	\$665 - indiv.	\$4,000
Federal Poverty Level plus \$20 disregard	\$884 - couple	\$6,000
SLMB	\$794 - indiv.	\$4,000
120% of Federal Poverty Level plus \$20	\$1,056 - couple	\$6,000
Medicaid - (Spend-Down)		
Gross income minus medical bills must be less than or equal to monthly amounts	\$522 - indiv.	\$2,000
	\$650 - couple	\$3,000
Long Term Care Medicaid	Spousal Income Allowance:	Spousal Assets:
Range Permitted Community Spouse (can be appealed)	\$1,295/mo - Minimum	\$15,348 Minimum
	\$1,919/mo - Maximum	\$76,740 Maximum
Supplemental Security Income*	Maximum Monthly SSI Payment	Maximum Assets
Aged Category (65 or older)		
SSI - Full Cost of Living	\$596.32 - indiv.	\$2,000
	\$901.72 - couple	\$3,000
SSI - Shared Living	\$506.76 - indiv.	\$2,000
	\$901.72 - couple	\$3,000
SSI - Household of Another	\$415.20 - indiv.	\$2,000
	\$680.80 - couple	\$3,000
SSI - Rest Home	\$763 - per person	\$2,000 indiv. \$3,000 couple

*Maximum income and payment amounts for SSI vary for aged, disabled and blind. Portions of *earned* income are disregarded. Generally, a person 65 or older living at home, paying at least 2/3 of the household expenses and has *only unearned income* of less than \$616.32 (\$921.72/couple) will qualify for SSI.

Rev:8/1/96

MASSACHUSETTS FREE CARE POOL

If you are a resident of Massachusetts (regardless of your citizenship or immigration status) in need of hospital care but are unable to afford it, you are entitled to free or reduced-cost care at any Massachusetts acute care hospital or health center.

BENEFITS

The free care pool will pay for your hospital bills if you are uninsured or underinsured. It will pay your bills for large co-payments, deductibles or uncovered hospital services. **However**, the free care pool only **pays for services billed through the hospital**, either inpatient or outpatient. The **pool does not pay for fees from private doctors or private labs who bill their patients separately from the hospital**. This means that when doctors are not employees of a hospital, patients would be billed by them separately from the hospital and would be responsible for paying for these bills without assistance from the free care pool.

ELIGIBILITY

1. You are automatically eligible for full free care if you are receiving assistance under the CenterCare Program or EAEDC (Emergency Aid to the Elderly, Disabled and Children Program).
2. You are eligible for **full free care** if your family income is below 200% of the federal poverty level.

200% FEDERAL POVERTY GUIDELINE - 1996

FAMILY SIZE	MONTHLY INCOME	YEARLY INCOME - 200% of Federal Poverty Guideline
1	\$1,290	\$15,480
2	\$1,727	\$20,720

3. You are eligible for **partial free care** if your family income is between 200% and 400% of the federal poverty level.

200%-400% FEDERAL POVERTY LEVEL - 1996

FAMILY SIZE	100% POVERTY LEVEL - YEARLY INCOME	200% YEARLY INCOME	400% YEARLY INCOME
1	\$7,740	\$15,480	\$30,960
2	\$10,360	\$20,720	\$41,440
3	\$12,980	\$25,960	\$51,920
4	\$15,600	\$31,200	\$62,400

The hospital will determine how much your family income exceeds the 200% federal poverty level. Then, it can bill you up to 40% of this amount.

For example, if a married couple has \$25,720 in income, they would have \$5,000. of income above the 200% federal poverty level. The hospital could bill them up to 40% of this \$5,000 dollars, or \$2,000.00. The remaining amount of the bill will be paid for my the free care pool.

4. You may be eligible for **partial free care** in paying the bill would result in financial hardship. Hospitals set individual criteria for determining hardship. Criteria may include other large medical bills or a recent drop in income due to illness, etc.

APPLICATION PROCESS

1. You can apply for free care at any time by requesting an application form from the billing department of the hospital you use. You do not have to wait until a health care crisis occurs before applying.

2. After signing and returning the forms, the hospital may ask for some verification of your income. The hospital must notify you in writing of their determination within 30 days after you submit your application.
3. At present, there are no appeal rights for persons who believe they were wrongfully denied use to free care funds. However, if you feel that you have been wrongfully denied, you may contact the supervising agency, the Office of the Massachusetts Uncompensated Care Pool, of the **Massachusetts Department of Medical Security**, at 1-800-238-0990 or 617-727-8300.
4. Non-english speaking persons can get information in other languages on the free care pool from the Mayor's Health Line, (617) 534-5050 or 1-800-847-0710.

INDIGENT PATIENT DRUG PROGRAMS

THE BENEFIT

Many prescription drug manufacturers make their medications available free-of-charge to patients who do not have the means to pay for them. Generally, this means patients who are not Medicaid eligible and patients who do not have a Medicare supplement with a prescription drug benefit.

The U.S. Senate Special Committee on Aging makes available an information paper which describes the **drugs covered** under the program, the **quantity** of the drug that can be obtained under the program, and the **eligibility criteria** that have to be met. This information paper is attached for your reference.

In October, 1993, Massachusetts enacted a law which permits doctors to distribute these drugs directly from their offices. Before the law was passed, Massachusetts physicians were not able to participate in the Indigent Patient Drug Programs of the drug manufacturers. As the program is still so new, some doctors and many clients will still be unaware of it.

APPLICATION PROCESS

First, identify the drug needed by the SHINE client and the drug's manufacturer. Then, call the drug manufacturer's Prescription Drug Patient Assistance Program in order to obtain an application. The telephone number of each drug company is listed in the 1996 directory. Ask for the application to be mailed to either you or directly to the SHINE client. The application must be completed first by the patient and then by the patient's doctor. Once the application is complete, the application must be mailed back to the drug company with the drug prescription attached. The manufacturer will mail the free drug supply to the physician's office.

ASSISTANCE

Patients may ask their doctor or the doctor's medical staff (if available) to assist them.

Or, a SHINE counselor may assist by contacting the drug company, requesting an application, and helping the client to complete his/her portion of the application. Then, the SHINE counselor can instruct the client to bring a stamped envelope to the doctors office and to request the doctor to complete it and mail it to the drug manufacturer's Indigent Patient Program as soon as possible.

For clients who will frequently have need to reapply for a free drug supply, it is a good idea to copy the semi-completed application after the applicant finished his/her portion of the application. In the future, the doctor's portion can be refilled and the application can be resent in a timely manner.

SHINE FACT SHEET

FREE PRESCRIPTION DRUG PATIENT ASSISTANCE PROGRAM

ASSISTANCE FOR PATIENTS AND DOCTORS AVAILABLE THROUGH THE SERVING HEALTH INFORMATION NEEDS OF ELDERS (SHINE) PROGRAM

DOCTOR CONTACTS THE MANUFACTURER OF PATIENT'S DRUG

An individual may call the manufacturer of their drug(s) to check if the drug is available through an Free Prescription Drug Patient Assistance Program. Or, the patient may ask a SHINE Counselor or a doctor to call the manufacturer. Every library and doctor's office has a drug guidebook titled "The Physician's Desk Reference", listing manufacturers' addresses and phone numbers. Also, SHINE Counselors have a 1996 Directory published by PHRMA that includes the names and addresses of the pharmaceutical companies participating in this program.

DOCTOR LEARNS ELIGIBILITY CRITERIA AND APPLICATION STEPS: A LETTER OR A UNIQUE APPLICATION FORM

The drug company will explain the **eligibility criteria** required under its free drug program. Companies use various eligibility guidelines, including: "no insurance", "doctor certifies unable to obtain drug elsewhere", "not eligible for any third party payment", "fixed income (no limit stated)", "physician's discretion". Generally, the physician makes the determination of eligibility and accepts the patient's word concerning his/her lack of insurance coverage and inability to pay.

The company will also explain their **application process**. Some companies accept the doctor's prescription and a **personal letter** which states the patient has no insurance coverage for prescription drugs, has a medical need for the prescription and lacks the financial means to pay for it. We encourage doctors to use the form letter which is attached to this FACT SHEET.

Other companies will mail an **application form** directly to the doctor. The doctor must complete it and return it with a prescription to the manufacturer. The doctor may need to contact the patient for further information to complete the application.

DISTRIBUTION OF THE DRUG

The manufacturer will mail the drugs directly to the physician's office, or, it will send a voucher for the drug to be picked up at the local pharmacy. Quantities vary depending upon the type of drug, duration of treatment, etc. The doctor's office must call the patient and arrange for the drug or voucher pick-up. The manufacturer will tell the doctor how to refill the prescription. The patient can remind the doctor when it is time to refill the prescription.

HOW DO SHINE COUNSELORS HELP?

While some people may feel comfortable asking their doctor for help, other people may ask a SHINE Counselor to act on their behalf. SHINE Counselors can help in many ways.

SHINE Counselors can identify the drug manufacturer involved, call the company and learn about its eligibility criteria and application process. It's important for the SHINE Counselor to discuss these details with the individual and let them decide if they want to proceed. If the person wishes to apply, the Counselor can contact the doctor to inform him/her of the individual's need for assistance, the manufacturer's name and phone number, and which application procedure to use.

If a personal letter from the physician is sufficient, the counselor can help by sending a form letter requesting assistance to the doctor for completion. The doctor may copy the form letter onto their personal stationery, sign it, attach the prescription and mail the letter to the drug manufacturer.

SHINE Counselors are trained and certified by the Executive Office of Elder Affairs. They provide information, counseling and assistance to elders and Medicare beneficiaries on health insurance and options. SHINE Counselors

work in Councils on Aging, Home Care Corporations, Agencies on Aging, local hospitals and multi-service centers. There are 18 Regional SHINE Programs in Massachusetts. The Regional Shine Program serving your area is:

{Regional SHINE Program Information}

SITE

TELEPHONE

Date

Drug Manufacturer

Address

Dear _____ :

I am writing on behalf of my patient who is in need of financial assistance with acquiring prescription medications.

Patient Name:

Patient Address:

Prescription Name:

This patient has no medical insurance to help pay prescription costs, has a limited income, and is not eligible for any public assistance programs.

Please accept the above named individual into the Prescription Drug Patient Assistance Program.

Sincerely,

Physician

Enclosure: Prescription Order

Date

Doctor

Address

Dear _____ :

I am writing on behalf of your patient, _____, who lacks insurance coverage for prescription drugs and the financial resources to purchase their drugs.

The drug they need is _____; it is made by the _____ pharmaceutical company; telephone _____ - _____ - _____. This company may provide this drug free of charge through their Prescription Drug Patient Assistance Program.

Each pharmaceutical company has specific eligibility requirements and application procedures. Therefore, you may want to contact them to determine if they will accept a personal letter or require you to use their application forms. Attached is a form letter that can be copied onto your personal stationery and submitted to the drug manufacturer with the appropriate prescription.

Thank you for your assistance in this matter.

Sincerely,

SHINE Counselor

cc: _____

(Patient's Name, Address and Telephone)

This section identifies the name of medications frequently prescribed for older Americans and the manufacturers of the drugs which are covered under an indigent patient program listed in this directory. If a drug that you take is NOT listed here, it still may be provided under an indigent patient program; it is suggested that your physician call the company to determine if it is covered under a program. If the manufacturer of a particular drug is not listed in this directory, it is suggested that the patient or physician call the company directly to determine if the company has an indigent patient program. Drug Manufacturer telephone numbers can be found in the Physician's Desk Reference.

DRUG/MANUFACTURER

A

Aci-Jel/Ortho
Activase/Genentech
Actimmune/Genentech
Adriamycin PFS/Adria
Adrucil/Adria
Aldactone/Searle
Aldomet/Merck
Alupent/Boehringer
Anaprox/Syntex
Ansaid/Upjohn
Antivert/Pfizer #1
Anusol HC/Parke-Davis
Apresoline/Ciba-Geigy
Aralen/Sanofi-Winthrop
Artane/Lederle
Asacol/Procter & Gamble
Atrovent/Boehringer
Augmentin/SmithKline
Axid/Eli Lilly
AZT (Retrovir)/Burroughs-Wellcome

B

Bactrim DS/Hoffman-LaRoche
Bactroban/SmithKline
Beconase/Glaxo
Beconase AQ/Glaxo
Betagan/Allergan
BICNU/Bristol-Myers #3
Blenoxance/Bristol-Myers #3
Bleph-10/Allergan
Blephamide/Allergan
Bucladin-S/Zeneca
BuSpar/Bristol-Myers #1

C

Calan/Searle
Calan SR/Searle
Capoten/Bristol-Myers #2
Capozide/Bristol-Myers #2
Carafate/Marion Merrell Dow
Cardene/Syntex
Cardizem/Marion Merrell Dow
Cardura/Pfizer #1
Carnitor/Sigma-Tau
Catapres/Boehringer
Ceclor/Eli Lilly
CEENU/Bristol-Myers #3
Ceftin/Glaxo
Cefzil/Bristol-Myers #1
Cipro/Miles
Clinoril/Merck
Clozaril/Sandoz
Cogentin/Merck
Compazine/SmithKline
Cordarone/Wyeth-Ayerst
Corgard/Bristol-Myers #2
Corzide/Bristol-Myers #2
Coumadin/DuPont Merck
Cyclospasmol/Wyeth Ayerst
Cytotec/Searle
Cytovene/Syntex
Cytosan/Bristol-Myers #3

D

Dalmane/Hoffman-LaRoche
Danocrine/Sanofi-Winthrop
Dantrium/Procter & Gamble

Desyrel/Bristol-Myers #1
Diabinese/Pfizer #1
Diamox/Lederle
Dienestrol/Ortho
Diflucan/Pfizer #2
Dilantin/Parke-Davis
Diprolene/Schering-Plough
Diprosone/Schering-Plough
Dolobid/Merck
Duricef/Bristol-Myers #1
Dyazide/SmithKline #1
Dymelor/Eli Lilly

E

E-Mycin/Upjohn
Efudex(Fluorouracil Inj)/Hoffman
Eldepryl/Sandoz
Eminase/SmithKline #2
Epogen/Amgen
Ergamisol/Janssen
Erycette/Ortho
Estrace/Bristol-Myers #1
Eulexin/Schering-Plough

F

Feldene/Pfizer #1
Flexeril/Merck
Floxin/Ortho
FML/Allergan
Fulvicin/Schering-Plough

G

Glucotrol/Pfizer #1

H

Halcion/Upjohn
Haldol/McNeil
Hismanal/Janssen
Hivid/Hoffman-LaRoche
HMS/Allergan

I

Idamycin/Adria
Ifex/Bristol-Myers #3
Imuran/Burroughs-Wellcome
Indocin/Merck
Insulin Humulin and Iletin/Eli Lilly
Interferon-A Recomb/Hoffman
Intron-A/Schering-Plough
Isoptin/Knoll
Isordil/Wyeth-Ayerst

K

K-Lyte/Bristol-Myers #1
Keflex/Eli Lilly
Kerlone/Searle
Kinesed/Zeneca
Klonopin/Hoffman-LaRoche
Klotrix/Bristol-Myers #2

L

Lanoxin/Burroughs-Wellcome
Lasix/Hoechst-Roussel
Leucovorin Calcium/Lederle
Leukine/Immunex
Librium/Hoffman-LaRoche
Limbitrol/Hoffman-LaRoche
Lioresal/Ciba-Geigy

Lo/Ovral/Wyeth-Ayerst
Lopid/Parke-Davis
Lopressor/Ciba-Geigy
Lotrimin/Schering-Plough
Lotrisone/Schering-Plough
Loxapine/Lederle
Lyophilized Cytosan/Bristol-Myers #3

M

Macrochantin/Procter & Gamble
Maxzide/Lederle
Medrol/Upjohn
Megace/Bristol-Myers #3
Meproin/Burroughs-Wellcome
Mesnex/Bristol-Myers #3
Mevacor/Merck
Micronase/Upjohn
Minipress/Pfizer #1
Minocin/Lederle
Monistat/Ortho
Monistat-Derm/Ortho
Monopril/Bristol-Myers #2
Motrin/Upjohn
Myambutol/Lederle
Mycostatin/Bristol-Myers #1

N

Naprosyn/Syntex
Nasalide/Syntex
Natalins RX/Bristol-Myers #1
Neosar/Adria
Neupogen/Amgen
Nicorette/Marion Merrell Dow
Nimotop/Miles
Nitrodisc/Searle
Nizoral/Janssen
Nolvadex/Zeneca
Nordette/Wyeth-Ayerst
Normodyne/Schering-Plough
Norpace/Searle
Noroxin/Merck
Norplant System/Wyeth-Ayerst

O

Oculinium/Allergan
Optimine/Schering-Plough
Orinase/Upjohn
Orudis/Wyeth-Ayerst
Ovcon/Bristol-Myers #1

P

Pancrease/McNeil
Paralon Forte DSC/McNeil
Paraplatin/Bristol-Myers #3
Parlodel/Sandoz
Pavabid/Marion Merrell Dow
Pepcid/Merck
Periactin/Merck
Persantine/Boehringer
Persa-Gel/Ortho
Pilogan/Allergan
Platinol/Bristol-Myers #3
Plendil/Merck
Ponstel/Parke-Davis
Pravochol/Bristol-Myers #2
Premarin/Wyeth-Ayerst
Prilosec/Merck
Prinivil/Merck
Procain/Parke-Davis
Procandia/Pfizer #1
Procrit/Ortho Biotechnology
Prokin/Hoechst-Roussel
Pronestyl SR/Bristol-Myers #2
Propine/Allergan
Proscar/Merck
Prostat/Ortho

Proventil/Schering-Plough
Provera/Upjohn
Prozac/Eli Lilly
Pyridium/Parke-Davis

Q

Questran/Bristol-Myers #2
Quinamm/Marion Merrell Dow

R

Relafen/SmithKline
Rheumatrex/Lederle
Rocaltrol/Hoffman-LaRoche
Rocephin/Hoffman-LaRoche
Rythmol/Knoll

S

Sandimmune/Sandoz
Sandoglobulin/Sandoz
Sandostatin/Sandoz
Santyl/Knoll
Sectral/Wyeth-Ayerst
Septra DS/Burroughs-Wellcome
Seldane/Marion Merrell Dow
Sinemet/DuPont-Merck
Sorbitrate/Zeneca
Spectazole/Ortho
Sporanox/Janssen
Sultrin/Ortho
Symmetrel/DuPont Merck
Synalar/Syntex
Synemol/Syntex

T

Tagamet/SmithKline
Tarabine/Adria
Tenormin/Zeneca
Terazol/Ortho
Timolol/Merck
Timoptic/Merck
Tofranil/Ciba-Geigy
Tolectin/McNeil
Trandate/Glaxo
Tridesilon Cream/Miles
Triostat/SmithKline #2
Triphasil/Wyeth-Ayerst

V

Vagistat/Bristol Myers #1
Valium/Hoffman-LaRoche
Vascor/McNeil
Vasodilan/Bristol-Myers #3
Vasoretic/Merck
Vasotec/Merck
VePesid/Bristol-Myers
Verelan/Lederle
Vincasar/Adria
Voltaren/Ciba-Geigy

W

Wellcovorin/Burroughs-Wellcome
Wytensin/Wyeth-Ayerst

X

Xanax/Upjohn

Z

Zantac/Glaxo
Zestril/Zeneca
Zestoretic/Zeneca
Zithromax/Pfizer #1
Zolof/Pfizer #1
Zostrix/Knoll
Zovirax/Burroughs-Wellcome
Zyloprim/Burroughs-Wellcome

Indigent Patient Program

Drug Application Form

Revised 11/93

Instructions: Fill in all the blanks you can, then take this form to your doctor. Your physician, or other practitioner, must complete it, and MAIL IT DIRECTLY TO THE DRUG COMPANY. Your doctor should call the drug company first to see if they will accept this form, or send their own.

To: _____ From: _____
(Name of Drug Company) (Name of practitioner)

One of my patients, _____ (name) _____, is taking the following medication manufactured by your company:

Drug Name	Dosage	Frequency taken	Other Details

My patient would like to apply for your indigent patient program. This patient declares their annual gross income and assets are as follows:

Source of Income (Social Security, Pension, etc.)	Amount Yearly

Assets: List below the current value of any stocks, bonds, certificates of deposit (CDs), bank accounts, savings accounts or any other investments the patient owns:

Checking Account: \$ _____ current balance Stocks Value: \$ _____
Savings Account: \$ _____ current balance Bonds Value: \$ _____
CDs: \$ _____ current value Other Assets: \$ _____

☐ This patient does not have any public or private insurance for prescription drugs.

PRINTED NAME OF PRACTITIONER: _____

License # _____ DEA # _____ Signature: _____
(do not use stamp)

Practitioner's Address: _____ City _____ State _____ Zip _____

Telephone: (____) _____

Signed: _____ Address _____ City _____ State _____ Zip _____

(signature of patient)

MAIL THIS FORM TO THE DRUG COMPANY (Call 1-800-PMA-INFO for addresses.)

LIST ONLY ONE DRUG ON THIS FORM

SOME DRUG COMPANIES WILL NOT ACCEPT THIS FORM. ASK FOR THEIR FORM

IMPORTANT: ATTACH A COMPLETED PRESCRIPTION FORM WITH THIS APPLICATION

LONG-TERM CARE INSURANCE

- TOPICS:**
- . LONG-TERM CARE - NEED AND DEFINITION**
 - . COSTS OF LONG-TERM CARE**
 - . MEDICARE**
 - . MEDICAID**
 - . LONG-TERM CARE INSURANCE DEVELOPMENT**
 - . PRIVATE LONG TERM CARE INSURANCE**
 - . MASSACHUSETTS STANDARD REQUIREMENTS
FOR NON-GROUP POLICIES**
 - . RANGE OF BENEFITS AND FEATURES**
 - . TIPS FOR BUYING NURSING HOME INSURANCE**
 - . LONG TERM CARE INSURANCE CONSUMER TIPS**
 - . LONG TERM CARE POLICY COMPARISON WORK
SHEET**

A. LONG TERM CARE NEEDS AND DEFINITION

1. Long term care (LTC) is the largest national catastrophic health expense in the United States. It may be defined as the kind of care an individual needs who is unable to care for him/herself because of a prolonged illness or disability. It can range from simple help with activities of daily living (ADLs) at home, such as bathing, dressing, eating, transferring, walking and toileting, to highly skilled nursing care. Long term care might be provided by any of the following:
 - a. Nursing homes
 - b. Home health agencies

- c. Adult day care and social day care programs
 - d. Custodial/rest homes
 - e. Private homes
 - f. Assisted Living Residences
2. For purposes of this course the study will concentrate on long term care insurance coverage for nursing home care and home health care. These policies may have other types of care featured as extra benefits.
3. Not many older adults can afford the costs associated with long term care for very long.
- a. The cost of a year in a nursing home varies from \$25,000 to \$50,000 or more.
 - b. Inflation causes today's current dollars to lose purchasing power in future years. For example, \$86.00 in 1993 will need to increase to be \$228.00 in twenty years in order to purchase the same health care services.
 - c. By the year 2001, the average annual family income for an elderly household is estimated to be \$19,566. This is obviously not enough to handle long-term care costs. ..
 - d. The number of frail elderly will probably double within the next 15 years and the need for long-term care goes up as one gets older. It is estimated that approximately 25% of those people who live to age 65 will eventually need some kind of long-term care. About 1/2 of those, or 12%, will stay "long term", meaning more than 90 days. The other 1/2, or 12%, will stay less than 90 days.

B. COSTS FOR LONG TERM CARE

1. Nationally, more than 50% of all nursing home expenses are paid out-of-pocket by individuals and their families.
2. Nationally, slightly less than 50% is paid by State Medicaid programs. In Massachusetts, that figure is 75%.
3. Medicare pays less than 2% of nursing home bills.
4. Medicare supplement insurance and employer health insurance seldom pay anything toward nursing home care.
5. Private long-term care (nursing home) insurance (in 1987) paid less than 2% of nursing home expenses.

C. MEDICARE COVERAGE

1. Medicare is not designed to cover the bulk of long-term care expenses. (See chapter 2).
 - a. Medicare pays for a skilled nursing level of care only following an approved hospital stay of at least three days duration, provided the patient has a medical need for skilled nursing care or rehabilitation services.
 - b. Even if the patient qualifies, Medicare pays only 20 days in full and 80 more days in part for nursing home stays.
2. While the average nursing home stay for patients in a single nursing facility is about 450 days, (in Massachusetts it is 910 days, or 2 1/2 years), Medicare has historically only paid for an average of 27 days of covered care per year. Clearly, Medicare should be considered as little or no help for nursing home care.

D. MEDICAID

1. Medicaid is the government program now paying the bulk of nursing home costs - \$17.6 billion in 1990 (National Association of Insurance Commissioners). It is designed to subsidize the payment capacity of nursing home residents who cannot afford to pay the full cost of nursing home care. (For more details on Medicaid qualifications, see the Public Benefits Chapter).
2. Medicaid eligibility varies from state to state. The criteria for qualifying is very complex.
 - a. **Only the eligibility specialists at the state Division of Medical Assistance's Long Term Care Eligibility offices have enough facts to determine whether an individual qualifies.**
 - b. An individual must meet both financial and medical need to qualify for long term care Medicaid. (For married nursing home residents, the income and asset rules are different. See your Public Benefits Chapter for details.)
 - (1) Financially the recipient must have insufficient income to pay the nursing home costs and assets limited to approximately \$2,000.00 (Income producing property and certain personal items may be treated differently or excluded.)
 - (a) Many people enter the nursing home using their own money first. When they have "spent down" their assets to qualifying levels, then they become Medicaid eligible.
 - (2) Medically, the individual seeking Medicaid assistance must have certification from the Coordination of Care unit of the state Home Care system and from a

physician that he/she indeed requires institutional care (at whatever level is appropriate: skilled, intermediate or custodial). This must be renewed periodically.

E. ADDITIONAL RESOURCES FOR LONG TERM CARE COVERAGE

1. **PRIVATE PAYMENTS** - Many people pay privately for long term care services.
2. **VETERAN'S BENEFITS** - Some long term care benefits may be available through Federal and State Veteran's Administrations. Contact the Veteran's Agent in your community for further details.
3. **OTHER PROGRAMS AND FUNDING RESOURCES** include, but are not limited to: home care corporations, supportive housing settings (eg. congregate housing, continuing care retirement communities, assisted living programs, adult foster care, home sharing arrangements), reverse equity home mortgages, home delivered meals programs, adult day health programs and social day care programs. Refer your customer to the local Council on Aging or Agency on Aging for details about these programs.

F. LONG TERM CARE INSURANCE EVOLUTION

1. Since its creation, Medicare was never intended to pay for medical nursing care in a nursing home below the level of skilled care. (Intermediate and custodial/personal care are not covered by Medicare.) The unfortunate part about Medicare's limited coverage was that Medicare refused to pay for any additional treatment once a person medically improved to the point where skilled care in a nursing home was no longer needed. However,

the patient might need to stay at the nursing home for the rest of his/her life because there was no one available at home to provide custodial/personal care.

2. In time, qualifying for skilled nursing care coverage (20 days paid in full) under Medicare has become even more restrictive. Fewer Medicare beneficiaries are able to receive payment for stays in a nursing home because of the required three days of hospitalization and other limiting requirements. The Medicare beneficiary cannot, therefore, rely on Medicare to provide nursing home care under normal conditions.
3. It wasn't until the late 1970's that a few nursing home insurance policies offered limited custodial coverage. In the mid 1980's, the insurance industry made a concentrated effort to produce policies with sufficient custodial care coverage to make them attractive to the average retired person. Some carriers were even expanding long term care coverage to offer varying amounts of home care and community based services. Today, nursing home care is recognized as only one facet of long-term care services.

G. PRIVATE LONG TERM CARE INSURANCE

1. Private long-term care insurance is a fairly new type of insurance which is designed specifically to pay for long term care services.
 - a. By 1991, over 2.4 million people nation-wide had purchased policies, but relatively few have filed claims and received any payments.
 - b. Long-term care insurance is private insurance designed specifically to pay for long term care services. Policies now on the market typically cover nursing home care and home health care, but the scope of benefits and terms of the policies vary tremendously. No policy, however, provides

full coverage for all expenses.

- c. Benefits are paid up to a specific number of days or visits. Almost all policies now available are "indemnity" plans, which pay a specified fixed dollar amount per day for nursing home or home health care regardless of your actual costs. The amount of the indemnity payment often differs by type of care (e.g., payment is lower for home health care than for nursing home care).
 - d. There are also specialty insurance contracts on the market, (e.g. dread disease policies or specialized care contracts for private duty nursing) which do cover some aspects of nursing home care, but which do not fall into the category of long-term care insurance. They are usually those issued prior to 10 years ago and their benefit amounts are usually minimal.
2. Long term care insurance policies may be an individual or group policy. Some companies sell both individual and group policies.
- a. **Individual insurance** is purchased directly from the company, often through an agent or broker.
 - b. **Group insurance** is generally purchased by an employer or an association and individuals are eligible for coverage because of their association or participation with the group; one example is the American Association of Retired Persons (AARP).
3. The **Massachusetts Division of Insurance** has limited legal authority over group policies; it has the authority to limit selling practices, but it does not have the authority to require minimum standard benefits for group policies. Also, group policies are not

filed with, or approved by, the Division of Insurance. As a result, the benefits and terms of group policies may vary significantly from the standards imposed on individual (non-group) policies.

- a. In Massachusetts, individual long term care insurance policies must meet specific minimum standards issued by the Division of Insurance (DOI). (211 CMR 65.05, Minimum Standards for Coverage.) **These standards apply ONLY to non-group policies issued after August 1, 1988.**
- b. Insurers sometimes structure their offerings as "group policies" to avoid regulation. This is often the case with group policies offered through "group trusts" based outside of Massachusetts. Sometimes an agent will start a sales pitch with an individual policy and later hand out a group policy. (The agent must inform the consumer that the group policy is different, and not regulated.) This is called **"Bait and Switch"** and is an illegal practice. Counselors should report these practices to the Division of Insurance and their SHINE Coordinator. Because of the lack of regulation over group policy benefits, you should be particularly careful when reviewing group policies, particularly those offered by group trusts.

H. THE MAJOR STANDARDS REQUIRED IN NON-GROUP (INDIVIDUAL) LONG TERM CARE INSURANCE POLICIES (211 CMR 65.00 et seq)

We suggest that you use the regulations governing individual (non-group) policies as a basis of comparison when reviewing group policies. The work sheet at the end of this chapter is designed for comparing individual or group policies. Also, see the form titled "Long Term Care Insurance Shopping Tips for Consumers" at the end of this chapter; it identifies important features and consumer concerns to consider when evaluating any policy.

1. **LEVELS OF CARE:** Individual policies must cover all three types of care in a nursing home: **skilled, intermediate and custodial**. Nursing home policies must also cover **home health care**. Some policies may cover only home health care. Policies **may** offer coverage for additional services, such as respite care, adult day care, homemaker services, personal care attendants and others.
2. **TYPES OF POLICIES:** Two kinds of policies may be sold:
 - a. A combination policy that offers at least both nursing home and home health benefits and;
 - b. A policy that offers **at least** home health benefits but does **NOT** offer any coverage for nursing home services.
 - c. Policies offering nursing home **only** coverage are **not** permitted.

3. **MANDATORY MINIMUM BENEFITS:** Mandatory minimum benefit requirements for non-group policies are:
 - a. Policies **must** offer at least 730 days, of a combined (and interchangeable) nursing home and home health care benefit for combination nursing home and home health care policies. The combined maximum amount of coverage per lifetime benefit cannot be less than \$36,500.00.
 - b. The nursing home benefit must cover all three levels (skilled, intermediate, custodial) in a nursing home for a minimum of \$50.00 per day.
 - c. Home health benefits must be at least 50% of the nursing home benefit. The benefits may not be less than \$25.00 per day. The maximum amount of coverage under a home health care only policy cannot be less than \$18,250.00.
 - d. No policy need pay for care in excess of actual costs.
4. **OPTIONAL ADDITIONAL BENEFITS:** Optional benefits in long term policies may include adult day care, adult foster care, chore care, homemaker services, respite care and social day care, or any other benefit approved by the Commissioner of Insurance. **Benefits must cover a reasonable portion of the cost of the service.**
5. **ELIMINATION PERIOD:** Policies **cannot** require an "elimination period" greater than 100 days of home health care and/or nursing home care. The elimination period (also known as the "deductible") is the waiting period between the time a policyholder begins to use covered services and the time when benefits are actually paid by the policy.

6. **PRIOR TREATMENT:** Prior treatment at a "higher level" of care **cannot** be required as a pre-condition for paying for benefits to be paid:

- a. Prior hospitalization **CANNOT** be required as a precondition for nursing home benefits.
- b. A level of care in a nursing home **CANNOT** be conditioned upon any other level of care in a nursing home (e.g. custodial care covered only if skilled care is given first).
- c. A nursing home stay **CANNOT** be required as a precondition for home health benefits.

7. **OTHER BENEFIT PROVISIONS:**

- a. Benefits **must** be available 365 days per year unless the maximum lifetime benefit period has expired or the maximum lifetime amount has been paid out.
- b. The days which are counted toward the lifetime maximum benefit period must be days for which you have actually received a benefit. For example if you received home health care three times a week for six months, you may count only those days on which a health benefit was received, not the entire six months.

8. **BENEFIT REQUIREMENTS BEFORE COVERAGE WILL BEGIN:** Skilled or intermediate nursing care, home health care and adult day care benefits may be conditioned on **either** being "medically necessary" or based upon a "disability".

- a. "Medically necessary" means services provided in accordance with accepted medical practice, delivered in the least intensive health care setting, and rendered not just for

the convenience of the insured and/or the insured's family, except when respite benefits are included in the policy.

- b. **"Disability"** means having a functional or cognitive inability to engage in certain Activities of Daily Living (ADLs) without human assistance. **No policy may require the inability to perform more than three ADLs.** The ADLs which must be used to evaluate the presence of disability are: eating, toileting, mobility, bathing, dressing and continence.
- 9. **ALZHEIMER'S DISEASE:** Alzheimer's disease and other organically based dementia **must** be covered if diagnosed after the policy is purchased. Insurers must have established criteria other than brain biopsy or autopsy for determining the existence of a demonstrable organic cause.
- 10. **ALCOHOLISM AND SUBSTANCE ABUSE:** Coverage **must** be provided for any physical condition that is caused or complicated by alcoholism or substance abuse. Other treatment for alcoholism or substance abuse, i.e., alcohol or drug detoxification or rehabilitation, may be excluded.
- 11. **PRE-EXISTING CONDITION:** A pre-existing condition is a condition that existed in the six months immediately before the policy's purchase. A policy may not exclude confinement or treatment which is the result of a pre-existing condition unless the confinement or treatment begins in the first six months following the covered person's effective date of coverage. Check with the agent to verify when the effective date of coverage will be.
- 12. **GUARANTEED RENEWABLE:** Policy renewal terms must be

no less restrictive than "guaranteed renewable", which means policies shall continue and may not be canceled for any reason other than nonpayment of premium. Guaranteed renewable does not mean that premiums cannot increase: premiums may be increased, but only for a **whole class** of policy holders.

13. **DISCLOSURE:** Policies **must** have a required disclosure statement to help consumers better understand the limitations and exclusions of their policy. All inflation rider offerings, whether at initial application or at any later date, must have a Statement of Disclosure, separate from the Statement of Disclosure for the main policy.

14. **INFLATION RIDER:** Companies must make an inflation adjustment option available at the time of application to all applicants with no additional underwriting; this means that the insured buying the policy with the inflation rider must be underwritten on the same basis as an insured who declines the inflation option.

a. Companies are not required to offer the inflation rider at any time other than at the time of application, although they may do so at their option. Whenever the inflation option is presented to a consumer, it must be accompanied with a separate "Disclosure Statement" for the inflation adjustment. The Disclosure Statement explains the method used to calculate the expected increase in the cost of benefits and related premiums.

I. CONSIDERATIONS IN SELECTING BENEFITS AND FEATURES:

In general, the benefits and features of private long term care insurance policies vary significantly; the important areas to focus on are:

1. **LENGTH OF BENEFIT COVERAGE**

- a. Most plans are purchased for a specific **period of time**; for example 2, 3 or 5 years. This means that the insurance company will pay a daily benefit for up to the number of years the individual chooses for any period of confinement. Some policies provide benefits for a lifetime and therefore never expire.

2. **ELIMINATION/WAITING PERIOD**

- a. This term applies to the **number of days** the individual must be in a nursing home before the long term insurance product will begin paying its benefits.
- b. Most plans offer three elimination or waiting periods: zero (0) days, 20 days, or 100 days. A plan with a "0" (zero) day elimination period will begin paying its benefits on the first day of eligible care. A plan with a 20 day elimination will begin paying on the 21st day of eligible care. A plan with a 100 day elimination period will begin paying on the 101st day of eligible care.
- c. The elimination period amounts to the same as a deductible and must be met before the plan will pay. For example, the policyholder might pay out-of-pocket for all covered services during the first 100 days, possibly \$45 - \$150 per day (depending upon the care received) before the insurance company begins paying any benefits.
- d. Remember that about 50% of the people who enter nursing homes stay less than 90 days. If a consumer buys a plan with a 100 day elimination period, he/she may be out of the

nursing home before the insurance begins paying benefits.

3. UNDERWRITING AND HEALTH QUESTIONS

- a. Companies are permitted to ask consumers about their health. This is one of the ways companies try to contain their level of risk. Most companies ask detailed health questions before deciding to insure the applicant. They are especially sensitive to such risks as heart problems, leukemia, rheumatoid arthritis, Alzheimer's, Parkinson's and those people already bedridden or having mental or physical disorders.
- b. The companies might prefer to decline your business rather than assume a bad risk.
- c. An applicant should complete his/her own health questionnaire to insure accuracy. Any false information or omissions on the health questionnaire could cause a claim to be denied in the future, and/or the policy could be cancelled and premiums returned.

(1) Example: Hector Pena saw a doctor last year for high blood pressure. For a time, Mr. Pena modified his diet and the symptoms of high blood pressure stopped. Six months ago, he filled out a health questionnaire for a LTC policy but failed to mention that he has high blood pressure. Last week, Mr. Pena became very dizzy at work, fainted, fell to the ground and broke his hip. He is now in a SNF and seeks to make a claim to the carrier of the LTC policy. The company may learn that he was diagnosed for high blood pressure and that he omitted reference to it when he applied for coverage. They could deny his claim and cancel his policy.

4. **RENEWABILITY OF POLICY AND PREMIUM**

- a. Individual policies for sale in this state are **guaranteed renewable** for life. This means that the company will not cancel the plan and the plan will remain in effect as long as the insured pays the premiums on time and has not misrepresented him/herself. Check to see if the **group** policy being considered by the SHINE client offers this feature.
- b. Premiums are almost never guaranteed for life. Most premiums will not stay at the same level as when purchased. All companies reserve the right to raise premiums if losses justify a price increase or whenever changes in the law increase the costs to the insurance company. Non-group (individual) rate increases must be approved by the Massachusetts Division of Insurance.

5. **NON-FORFEITURE BENEFITS**

- a. Non-forfeiture benefits return to policyholders part of the premiums they paid for the policy if they choose to cancel the policy or if coverage lapses because they are unable to pay the premium. The insurer may require the policyholder to have paid for the policy for a period of years (e.g. 5 years). The nonforfeiture benefit can come in many forms, including a paid-up policy with either reduced benefits or a shorter benefit period. Policy lapse rates are high for LTC insurance policies. A few insurers now offer non-forfeiture benefits.

- (1) Non-forfeiture benefits may be helpful to some people but they will cause the premiums to be higher.

- (2) A return of premium type of non-forfeiture benefit is not permitted in non-group LTC policies.

6. **WAIVER OF PREMIUMS**

- a. Most companies have a "waiver of premium" feature which states that after an insured is confined under a covered nursing home stay for a minimum number of days, no further premiums will be due while the confinement continues. Premiums will resume when the patient leaves the nursing home. The typical waiver of premium feature will take effect after 90 days of covered confinement.

7. **INFLATION ADJUSTMENT** - An additional option which allows for an increase in the future benefit amount.

- a. Due to inflation, a policy that pays \$50 per day will not be worth \$50 per day in 10 years.
- b. Some policies provide an automatic benefit increase each year (generally 5% a year for the first 10 years) in order to protect against the rising costs of long-term care.
- c. Other companies may offer the policyholder the right to purchase more daily benefits in later years without regard to the health status of the individual.
- d. Inflation adjustments can be helpful but will cause the premiums to be higher. Please note the difference in benefit between a **simple** and **compound** interest inflation benefit.

8. MISCELLANEOUS BENEFITS

- a. Some policies also cover such extra benefits as hospice, some ambulance charges, adult day care, respite care, homemaker services and chore services. Please note, policyholders with Medicare Parts A and B have good coverage for hospice and ambulance benefits.

J. COST OF LONG TERM CARE INSURANCE

1. The cost of long-term care insurance is often determined by: **the options selected, age at the time of issue, and gender.**
 - a. Females usually pay higher premiums because they tend to live longer.
 - b. The younger person pays less than an older person.
 - (1) A 25 year old might buy certain policies for \$8.00 per month, while that same policy for a 75 year old might cost \$250 - \$750 per month.
2. Premium cost is determined by age at the time the policy is issued and usually does not increase solely because of age as the policyholder grows older. However, some premiums increase because of age.
 - a. **Level premiums** in a policy means the premiums may change based on claims experience, but not age.
 - b. **Attained age premiums** in a policy mean the premiums may increase because of an increase in age **and** also because of claims experience.
3. The duration of the benefit payment period (2 years or 5 years),

inflation protection, and daily payment amounts represent the most expensive features in long-term care insurance.

- a. Features such as the waiver of premium and other benefits (such as adult day care, respite or home health care benefits) will also increase the premiums, though not as severely as the length of the payment period and the daily benefit amount features.
- b. Brief or no elimination periods will cause slight increases in the premium, but not as much as the total duration of the pay period and daily benefit levels.
- c. Only the insurance agent can quote an exact price after the applicant has selected his/her options and features.

COORDINATION WITH THE STATE'S MEDICAID REGULATIONS

Medicaid has the right to recover correctly paid assistance from the estate of (1) any deceased person who received Medicaid assistance after the age of 65, and (2) all medical services provided after October 1, 1993 to persons aged 55 to 65, and (3) all persons who are permanently institutionalized after with no reasonable expectation of returning home, regardless of the person's age, for medical payments made after March 22, 1991. Generally, **no recovery will be sought from the estate of a person who, on the date of admission to the nursing facility or medical institution, has long term care insurance coverage that meets the requirements of the regulations of the Division of Insurance.**

For details about this Medicaid rule, contact one of the Medicaid Long Term Care Eligibility offices listed below:

MassHealth Enrollment Center 1-800-322-1448 TTY 1-800-608-3300
The Schrafft Center
529 Main Street
Charlestown, MA 02129

MassHealth Enrollment Center 1-800-332-5545 TTY 413-785-4180
311 State Street
Springfield, MA 01105

MassHealth Enrollment Center 1-800-242-1340 TTY 508-828-4611
21A Spring Street
P.O. Box 711
Taunton, MA 02780-0711

March 27, 1996

SHINE PROGRAM

CONSIDERATIONS FOR CONSUMERS CONSIDERING PURCHASE OF LONG TERM CARE INSURANCE: ABILITY TO PAY, NEED, AND POST-DEATH PLANNING

1. First, as a consumer, you need to identify your motivation and need for long term care insurance. Think about these considerations:
 - a. The value of long term care insurance depends on a consumer's financial situation. Do I have enough income to pay my own way without insurance? Do I have assets to protect? Can I afford the premiums?
 - b. Are my assets of such an amount that they would be depleted in a short period of time? If paying privately for six months of nursing home care could deplete my assets, would long term care insurance be a worthwhile purchase?
 - c. Is there any reason to preserve my assets for my intended heirs or are there no intended heirs?
 - d. Remember, if one is aged 55-65, one may be paying premiums for 10-20 years before needing long term care. If the premiums are \$1,000 a year, one will have paid \$10,000 to \$20,000 in premiums during that time. Do I have a level of assets that requires that type of insurance investment to protect?
 - e. Do I have sufficient income to pay higher premiums if or when the premiums increase in the future?
 - f. Would I prefer to make a long-term care decision now or can I leave this decision-making to my family? Remember, once I get sick or develop a chronic health condition, I may not be able to buy long term care insurance.

2. Once these factors are considered, if the consumer wants to buy a LTC policy, then it is important to carefully select features which are appropriate for the consumer. Consider these factors:
 - a. Try not to over insure. Don't buy a policy with a \$100.00 per day benefit if only \$50.00 per day is needed. If I have enough income to pay a portion of the daily nursing home or home health care cost, then I can rely on a lower daily benefit level (e.g. \$50.00/day) from a long-term care policy.
 - b. Remember that nursing home costs increase yearly; an inflation adjustment feature may be very important, especially for younger purchasers.
 - c. The earlier one buys, the less expensive the policy, but the greater number of years paying the premium.
 - d. A home health care only policy may be needed more than a combined policy because most people who enter a skilled facility eventually go home. Only about 12% of the population over 65 ever uses a nursing home for several months or more.
 - f. Remember that 1/2 of all people using a nursing home stay less than 90 days. So, a shorter deductible period and a lesser number of total days for coverage may better serve my long term care needs.
3. Two consumer aids to help compare policies are the checklist titled "The SHINE Program - Long Term Care Insurance Shopping Tips for Consumers" and a guide book titled "A Consumer's Guide to Long Term Care Insurance". A consumer should compare at least three long term care insurance policies before deciding what to do. Comparisons are easier to do using the Long Term Care Insurance Policy Work Sheets provided in the Consumer Guide, pages 11-14. Contact the SHINE program for a copy of the Consumer's Guide to Long Term Care Insurance.

SHINE PROGRAM

LONG TERM CARE INSURANCE SHOPPING TIPS

FOR CONSUMERS

- * **Compare policies and companies.**- Do not buy the first policy you see. Shop around and compare at least three policies. Use the comparison work sheets provided by SHINE.
- * **Beware of the "Government" look.** - Do not be fooled by advertising that makes you think the government backs a certain insurance company.
- * **Ask a trusted friend or relative to join you when the agent visits.**
- * **Take your time - don't buy on the first sales visit.** - Although you might need the coverage immediately, - Do not let someone pressure or scare you into buying insurance. If you are unclear about coverage, ask questions. If you are still confused, call the SHINE Program for help. Most importantly, do not let an insurance company's advertising gimmicks such as "the last time to enroll" or "available only for a short time" force you to make a premature decision.
- * **Ask each agent or company for an "Outline of Coverage" as well as the Policy.** - They are required to provide both to you during their sales visit. Read both carefully.
- * **Do not stand for high pressure selling.** - Tell any high pressure agent to leave your home or you will call the police or the Insurance Commissioner's Office. Do not buy a policy just to get rid of a sales person. Do not loan money to salespersons (no matter how sad the story). Don't be embarrassed if you can't understand insurance - very few people do.
- * **Do not agree to buy or sign anything you don't understand.** - Get a full explanation from the selling agent or call your local SHINE Program for free impartial information.

- * **Read everything BEFORE you put your signature on an insurance application,** - Ask questions about anything you do not understand. If you are uncertain, don't sign it until you get information to your satisfaction.
- * **Don't buy multiple policies** - Before buying any new insurance, read your existing policies to see **what insurance you already have.** You don't know if you need new insurance until you know what you already have.
- * **Be careful about giving up an old policy for a new one.** Sometimes your old policy is as good as the new one. Make sure your new benefits are what you desire and need. Changing a policy often means a new pre-existing waiting period during which no benefits will be paid for any previous health condition. Be careful that you are not caught without coverage.
- * **When you have decided which policy to buy, answer all questions in the application truthfully,** - If any information in the application is wrong, the company can deny a claim or even cancel your policy. It is important to answer all questions on an application truthfully, especially any questions on your medical history. Check the application yourself to be sure all answers are accurate and complete.
- * **Never sign a blank application.**
- * **Do not pay cash.** - Pay by check or money order and make it payable to the insurance company. To avoid potential problems, do not make checks payable to the agent. Be sure to get a receipt and keep the agent's business card with the agent's name, business address, and business telephone number. Buy from an agent who will service your insurance needs as well as sell policies.
- * **Pay your premium on time.** - To avoid any lapse in coverage, make sure your premiums are paid on time and within your grace period.
- * **Keep your policies, receipts, claims and records in a safe place.** All documents should be kept together so that it will be easy to file claims

* **Check on the financial stability of the company you are considering.** Reference departments of **local libraries** contain financial ratings and information on insurance companies. The ratings carry no guarantee of accuracy but can provide information on how some analysts view the financial health of particular insurance companies.

By **telephone**, you may contact a rating reference library as well as a these financial rating companies:

Rating Library	617-227-2087
Duff and Phelps	312-368-3157
Moody's Investor Service	212-553-1653
Standard and Poor's	212-208-1527

* **Use the free look provision.** - Once you have received the policy (usually within 90 days), keep the envelop it arrived in order to prove the date of receipt. Or, request the agent to give you a signed delivery receipt when he or she hand delivers the policy to you. Make sure you review the policy and the required Disclosure Statement during your **Free Look** period. Do not rely on the verbal information from the agent. Massachusetts law governing non-group policies only requires a Free Look period of 10 days. However, some insurance companies offer a 30 day Free Look period; check the contract.

You have a **Free Look Period** of 10 days to decide whether or not you want a non-group long term care policy. **If you decide you do not want this policy for whatever reasons, you may return the policy (to the company, not the agent) and get a full refund.** Return the policy with a letter requesting a full refund, **BY CERTIFIED MAIL**, to the company and **OBTAIN A MAILING RECEIPT. MAIL IT BACK WITHIN THE FREE LOOK PERIOD.** You should get a full refund within 30 days. If you do not, call your local agent or company. If this does not work, then call the Division of Insurance, Consumer Services Department, at 617-521-7777 to report your complaint.

LONG-TERM CARE INSURANCE EXERCISE

Exercise 1:

1. Where can long-term care be provided? Circle all possible answers.
 - a. home
 - b. bowling alley
 - c. adult day health center
 - d. nursing home
 - e. board and care home
 - f. daughter's place of work
2. Not many older adults can afford to pay for long term care for very long.
T_____ F_____
3. Medicare pays only for _____ nursing care.
4. What government insurance program pays for most nursing home costs?

5. To which agency do you apply for Medicaid?

6. In Massachusetts, an individual long-term care insurance policy must cover all levels of nursing home care. T_____ F_____

7. For individual (non-group) LTC insurance policies, Alzheimer disease may not be excluded once the policy becomes effective.
T _____ F _____
8. What is meant by "waiver of premium"?

9. Some plans offer LT benefits for as long as you stay in a nursing home? T _____ F _____
10. It is important that an applicant fill out his/her own health questionnaire. T _____ F _____
11. A person living on a limited, fixed income should purchase long term care insurance. T _____ F _____
12. What are some consumer tips a Counselor could give someone who is considering buying a long-term care policy?
- a. _____
- b. _____
- c. _____

13. Circle the types of "gatekeeper"/conditions used to decide when a policyholder will receive payment for individual (non-group) policies.
- a. he/she cannot drive to work any longer
 - b. he/she needs aid in bathing and dressing each morning
 - c. the daughter who cooked extra meals for him moved away.
 - d. the doctor thinks he/she needs personal care assistance daily due to medical needs.
14. What document must a sales person provide during a sales visit? _____
15. What documents show what is actually covered by a policy?
- a. _____
 - b. _____
16. Name the three features of a long term care insurance policy which cause premiums to significantly increase.
- a. _____
 - b. _____
 - c. _____
17. The Free Look period for non-group individual LTC policies is at least _____ days long; some contracts offer a _____ day Free Look period.

March 27, 1996



THE COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF CONSUMER AFFAIRS

DIVISION OF INSURANCE

470 ATLANTIC AVENUE

BOSTON, MA 02210-2223

(617) 521-7794

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PRISCILLA H. DOUGLAS

SECRETARY

LINDA RUTHARDT

COMMISSIONER

APPROVED INDIVIDUAL LONG-TERM CARE POLICIES

According to 211 CMR 65.00

March 31, 1996

	<u>Company Name</u>	<u>Approval Date</u>
1.	ALLIANZ LIFE INSURANCE COMPANY OF NORTH AMERICA Life Care Administrative Office P.O. Box 4243 Woodland Hills, CA 91365 (818) 887-4436 <i>Policy #s:</i> N-2350-P-MA (comprehensive nursing home & home health care policy)	(3/24/95)
2.	AMERICAN TRAVELLERS LIFE INSURANCE COMPANY Glenview Corporate Center P.O. Box 8506 Bensalem, PA 19020-8506 1-800-441-3978 or (215) 244-1600 <i>Policy #s:</i> ATL-LTC-3(MA) (comprehensive nursing home & home health care policy) ATL-HHC-1(MA)(home health care only policy) LTC6MA (comprehensive nursing home & home health care policy)	(12/6/93) (12/6/93) (7/18/95)
3.	AMEX LIFE ASSURANCE COMPANY 1650 Los Gamos Drive San Rafael, CA 94903-1899 1-800-456-3399 or 1-800-832-6868 <i>Policy #s:</i> 50023E (no longer being marketed effective June 15, 1995) 7000AR (comprehensive nursing home & home health care policy)	(5/27/93) (4/5/95)

APPROVED INDIVIDUAL LONG-TERM CARE POLICIES

	<u>Company Name</u>	<u>Approval Date</u>															
4.	<p>BANKERS LIFE AND CASUALTY COMPANY 222 Merchandise Mart Plaza Chicago, IL 60654-9988 (312) 777-7000</p> <p><i>Policy #s:</i></p> <table> <tr> <td>GR-N020</td><td>(comprehensive nursing home & home health care policy)</td><td>(7/24/90)</td></tr> <tr> <td>N001</td><td>(home health care only policy)</td><td>(7/30/90)</td></tr> <tr> <td>GR-N050</td><td>(comprehensive nursing home & home health care policy)</td><td>(9/8/93)</td></tr> <tr> <td>GR-N105</td><td>(comprehensive nursing home & home health care policy)</td><td>(8/16/95)</td></tr> <tr> <td>GR-N080</td><td>(home health care only policy)</td><td>(12/12/95)</td></tr> </table>	GR-N020	(comprehensive nursing home & home health care policy)	(7/24/90)	N001	(home health care only policy)	(7/30/90)	GR-N050	(comprehensive nursing home & home health care policy)	(9/8/93)	GR-N105	(comprehensive nursing home & home health care policy)	(8/16/95)	GR-N080	(home health care only policy)	(12/12/95)	
GR-N020	(comprehensive nursing home & home health care policy)	(7/24/90)															
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GR-N105	(comprehensive nursing home & home health care policy)	(8/16/95)															
GR-N080	(home health care only policy)	(12/12/95)															
5.	<p>BANKERS MULTIPLE LINE INSURANCE P.O. Box 219065 Dallas, TX 75221-9065 1-800-643-9917 *ask for Stefanie Grantello</p> <p><i>Policy #s:</i></p> <table> <tr> <td>D-N050</td><td>(comprehensive nursing home & home health care policy)</td><td>(8/16/93)</td></tr> </table>	D-N050	(comprehensive nursing home & home health care policy)	(8/16/93)													
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6.	<p>BANKERS UNITED LIFE ASSURANCE COMPANY P.O. Box 93020 Hurst, TX 76053 1-800-322-1434</p> <p><i>Policy #s:</i></p> <table> <tr> <td>GCPRIICMA794</td><td>(comprehensive nursing home & home health care policy)</td><td>(7/18/95)</td></tr> </table>	GCPRIICMA794	(comprehensive nursing home & home health care policy)	(7/18/95)													
GCPRIICMA794	(comprehensive nursing home & home health care policy)	(7/18/95)															
7.	<p>CONNECTICUT NATIONAL LIFE INSURANCE COMPANY 304 North Main Street P.O. Box 120 Rockford, IL 61105-0120 1-815-987-5000</p> <p><i>Policy #s:</i></p> <table> <tr> <td>IHP-8696-MA</td><td>(comprehensive nursing home & home health care policy)</td><td>(1/30/96)</td></tr> <tr> <td>IHP-8702-MA</td><td>(home health care only policy)</td><td>(1/30/96)</td></tr> </table>	IHP-8696-MA	(comprehensive nursing home & home health care policy)	(1/30/96)	IHP-8702-MA	(home health care only policy)	(1/30/96)										
IHP-8696-MA	(comprehensive nursing home & home health care policy)	(1/30/96)															
IHP-8702-MA	(home health care only policy)	(1/30/96)															

APPROVED INDIVIDUAL LONG-TERM CARE POLICIES

	<u>Company Name</u>	<u>Approval Date</u>
8.	<p>CONTINENTAL CASUALTY COMPANY (CNA) CNA Plaza Chicago, IL 60685 1-800-327-2430</p> <p><i>Policy #s:</i></p> <p>P1-15203-A20 (comprehensive nursing home & home health care policy) (4/24/92) P1-16356-A20 (comprehensive nursing home & home health care policy) (4/24/92) P1-18215-A20 (comprehensive nursing home & home health care policy) (4/7/94) P1-18876-A20 (comprehensive nursing home & home health care policy) (8/25/94) P1-21295-A20 (comprehensive nursing home & home health care policy) (10/3/94) P1-21300-A20 (comprehensive nursing home & home health care policy) (10/3/94)</p>	
9.	<p>CONTINENTAL GENERAL INSURANCE COMPANY 8901 Indian Hills Drive P.O. Box 247007 Omaha, NE 68124-7007 (402) 397-3200</p> <p><i>Policy #s:</i></p> <p>431 (MA) (comprehensive nursing home & home health care policy) (8/30/95)</p>	
10.	<p>FIRST PENN-PACIFIC LIFE INSURANCE COMPANY 1300 South Clinton Street or ATTN: Charlie Erickson P.O. Box 1110 316 Main Street Fort Wayne, IN 46801 Worcester, MA 01608 (219) 455-2941 (508) 756-1216</p> <p><i>Policy #s:</i></p> <p>HF-2950MA (comprehensive nursing home & home health care policy) (4/22/93) HF-2504MA (comprehensive nursing home & home health care policy) (4/22/93)</p>	
11.	<p>IDS LIFE INSURANCE IDS Tower 10 Minneapolis, MN 55440 (612) 671-3733</p> <p><i>Policy #s</i></p> <p>30227-MA (comprehensive nursing home & home health care policy) (2/17/95)</p>	

APPROVED INDIVIDUAL LONG-TERM CARE POLICIES

	<u>Company Name</u>	<u>Approval Date</u>
12.	<p>JOHN ALDEN LIFE INSURANCE COMPANY 21031 Ventura Blvd. P.O. Box 4243 Woodland Hills, CA 91365-4243 1-800-932-6796</p> <p><i>Policy #s:</i> J-5762-P-MA (comprehensive nursing home & home health care policy) (7/22/93) J-5875-P-MA (comprehensive nursing home & home health care policy) (8/31/95)</p>	
13.	<p>JOHN HANCOCK MUTUAL INSURANCE COMPANY John Hancock Place P.O. Box 111 Boston, MA 02117 1-800-543-6415</p> <p><i>Policy #s:</i> LTC-MA-91 (no longer being marketed effective 11/8/93) (10/1/91) LTC-94 MA2 (comprehensive nursing home & home health care policy) (11/8/93)</p>	
14.	<p>LINCOLN NATIONAL INSURANCE COMPANY 1300 South Clinton Street or ATTN: Charlie Erickson P.O. Box 1110 316 Main Street Fort Wayne, IN 46801 Worcester, MA 01608 (219) 455-2941 (508) 756-1216</p> <p><i>Policy #s:</i> HL-2950MA (comprehensive nursing home & home health care policy) (4/22/93) HL-2504MA (comprehensive nursing home & home health care policy) (4/22/93)</p>	
15.	<p>MONUMENTAL LIFE INSURANCE COMPANY P.O. Box 93020 Hurst, TX 76053 1-800-322-1434</p> <p><i>Policy #s:</i> GCPRIICMA794 (comprehensive nursing home & home health care policy) (7/18/95)</p>	

APPROVED INDIVIDUAL LONG-TERM CARE POLICIES

	<u>Company Name</u>	<u>Approval Date</u>
16.	<p>MUTUAL OF OMAHA Mutual of Omaha Plaza Omaha, NE 68175 (402) 343-7600</p> <p><i>Policy #s:</i> LTC-9 (comprehensive nursing home & home health care policy)</p>	(12/16/93)
17.	<p>NEW YORK LIFE INSURANCE COMPANY Long-Term Care Division 51 Madison Avenue New York, NY 10010 (212) 576-7000</p> <p><i>Policy #s:</i> 21073 (MA) (comprehensive nursing home & home health care policy)</p>	(6/27/94)
18.	<p>PFL LIFE INSURANCE COMPANY P.O. Box 93005 Hurst, TX 76053 1-800-338-0256</p> <p><i>Policy #s:</i> LTC 3 (MA) 1091 (REV92) (comprehensive nursing home & home health care policy) LTC 3R (MA) 1091 (REV92) (comprehensive nursing home & home health care policy)</p>	(1/25/94) (1/25/94)
19.	<p>PIONEER LIFE INSURANCE COMPANY OF ILLINOIS 304 North Main Street P.O. Box 120 Rockford, IL 61105-0120 1-815-987-5000</p> <p><i>Policy #s:</i> IHP-9696-MA (comprehensive nursing home & home health care policy) IHP-9702-MA (home health care only policy)</p>	(12/19/95) (12/19/95)

APPROVED INDIVIDUAL LONG-TERM CARE POLICIES

	<u>Company Name</u>	<u>Approval Date</u>
20.	<p>TIME INSURANCE COMPANY 501 West Michigan P.O. Box 3050 Milwaukee, WI 53201-3050 1-800-377-7311</p> <p><i>Policy #s:</i></p> <p>4043-MA (comprehensive nursing home & home health care policy) (5/27/93) 4042-MA (home health care only policy) (5/27/93) 4044-MA (comprehensive nursing home & home health care policy) (1/23/96)</p>	
21.	<p>TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY Long-Term Care Insurance Department P.O. Box 2310 Los Angeles, CA 90051-0310 1-800-227-3740</p> <p><i>Policy #s:</i></p> <p>LTC 104-194-MA (comprehensive nursing home & home health care policy) (4/3/95) LTC 106-194-MA (home health care only policy) (4/3/95)</p>	
22.	<p>THE TRAVELERS INSURANCE COMPANY One Tower Square Hartford, CT 01683 (203) 277-0111</p> <p><i>Policy #s:</i></p> <p>H-LTC 2J-21 (comprehensive nursing home & home health care policy) (1/11/91) H-LTC 2J-27 (comprehensive nursing home & home health care policy) (5/11/91) H-LTC3J-6 (comprehensive nursing home & home health care policy) (11/11/93) H-LTC3JP13 (comprehensive nursing home & home health care policy) (7/7/94)</p>	

APPROVED INDIVIDUAL LONG-TERM CARE POLICIES

Company Name

Approval Date

23. UNUM LIFE INSURANCE COMPANY
2211 Congress Street
Portland, ME 04122
(207) 770-2211

Policy #s:

LTC6092	LTC6392	LTC7092	LTC7392
LTC6192	LTC6492	LTC7192	LTC7492
LTC6292	LTC6592	LTC7292	LTC7592

COUNSELING SKILLS

- TOPICS:**
- * INTRODUCTION**
 - * COMMUNICATION**
 - * INTERVIEWING**
 - * COUNSELING GUIDELINES**
 - * COUNSELING STEPS**
 - * COUNSELING TOOLS**

INTRODUCTION:

As a SHINE Counselor, you will be called upon to provide accurate, objective health insurance information in a supportive manner that will enable the client to make well-informed decisions. SHINE Counselors have a complex job to do. You are trying to share complicated information with people. This task is complicated by the fact that the person with the need for the information may have many barriers to hearing and understanding the SHINE information.

1. SHINE volunteers conduct most of their work on a one-to one basis with seniors. All volunteers bring a unique experience base and set of skills to their counseling sessions. The success or effectiveness of these counseling sessions is a product of both the volunteer and the senior seeking assistance.
2. SHINE volunteers often find themselves in situations which may be confusing. People will want you to recommend or endorse a specific insurance policy. They may want you to tell them what to do relating to all kinds of insurance decisions. Sometimes, you will find yourself in a situation where the persons with whom you are working begin sharing very personal information or may be overcome with feelings. You may be

the first "objective" person they have talked to since their spouses died or became ill. The fact that you are talking about their health and other personal information related to insurance needs may provide the open door for their previously closed-in feelings. Don't be alarmed.

3. Later in this chapter, we'll discuss some skills for dealing with these situations. Throughout this chapter, there will be examples of particular techniques or skills. Don't worry about the specific words or phrases used in examples. We all use words differently. The intent of the examples is to present a way of addressing an issue in a manner that has been helpful to others. Be yourself.

COMMUNICATION:

Communication is the transfer of an idea, thought or feeling. Making sure SHINE volunteers are well-informed regarding insurance and Medicare is not enough to guarantee effective help. The information can't be transferred if the listener can't receive it. This section is designed to help identify principles of clear communication and the barriers you might find. It will also present some tools to assist you in dealing with people who need assistance from the SHINE Program.

1. We communicate in two ways - verbally and non-verbally.
 - a. Verbal communication is the use of words, symbols and sounds. (When we write or speak, we use verbal communication.) Verbal communication is often the most effective way to transfer information about complex issues.
 - b. Non-verbal communication is often referred to as body language. It includes facial expressions, gestures, and the general way we hold or move our own bodies as we communicate with people.

(1) Imagine seeing two people ahead of you on the street. One of them is glad to see you and the other would like to avoid you. Picture in your mind how they can communicate those feelings to you, before anyone has a chance to speak. That is non-verbal communication.

2. There are many barriers to effective verbal communication that we can anticipate and reduce.

- a. The first barrier is in **effective delivery**. You may have experienced listening to someone who mumbled, or talked too fast or too softly for you to hear what was being said. It is important to remember to speak clearly, with enough volume and at a speed that helps the listener get the message. Since most of the people we are talking to are seniors, it's important to be sure we are speaking loudly enough. The need for increased volume may mean that you will need to find a place to talk that allows privacy even when the volume is high.
- b. People with **hearing difficulties** often find it easier to hear when there are few competing sounds.
- c. **Volume** - if someone doesn't understand what is being said, it usually doesn't help to repeat the same information in a louder voice. Be on the alert for whether what you said wasn't heard or wasn't understood.
- d. Another barrier to transferring information about insurance to someone is the use of **words and concepts that may not be familiar** to the general population. These words and concepts are called "jargon". You have had some special training, and you may have considerable exposure dealing with what you consider to be common insurance or Medicare issues. The client you are assisting will hardly ever share your experience or awareness. For example,

"beneficiary", "Part B" and "co-payments" may not be familiar terms.

e. Even if the terms are familiar, **the person may not understand the processes that are used by Medicare or insurance companies in determining and paying claims.** Being well-educated or successful in business does not guarantee that a person understands the language of insurance or Medicare. Some seniors you assist may have little education, they may even be illiterate. This complicates matters, but it doesn't affect their need for the information. So be careful about jargon and make sure the person understands what you are talking about before you proceed.

f. Sometimes the person's **inability to understand complex information** will create its own barrier to effective communication.

(1) If you find yourself assisting seniors who appear easily confused or unable to understand the basics of your responses to their concerns, it is appropriate to ask if they have a grown child (or someone else that they would feel comfortable with) who might go through the process with you.

g. You may also experience difficulty with a senior whose **inability to understand English** may create problems. If there isn't another SHINE volunteer fluent enough in the second language available to handle the matter, you may suggest that the senior bring someone he or she trusts to assist in translation.

3. Additionally, our own personal values, attitudes, needs, culture and experiences can block effective communication. Both people involved bring these elements. Sometimes, these elements or the differences

between the two people can create barriers to effectively sharing an idea or concept.

- a. An example of such a barrier might be found when a female volunteer meets with a male senior who believes that men must never discuss their financial (or medical/physical health) circumstances with women. Other beliefs or family values may also interfere.
- b. No one expects that every volunteer and every senior seeking assistance will be able to work effectively with each other. If you are uncomfortable with a person or if that person seems uncomfortable with you, it is appropriate to suggest another volunteer. This is especially true if you feel this awkwardness might interfere with the valuable SHINE information and assistance that could be provided.

4. Effective verbal communication includes consistent non-verbal communication.

- a. A common barrier to effective sharing of information is the **mixed message** some people send to their listeners. Imagine a SHINE volunteer who says, "I can't recommend any given policy over another." While reading the two policies being compared, the volunteer shakes his or her head "no" several times through one, and nods "yes" several times while reading the second. This is a **mixed message**. The body language (the non-verbal communication) said the volunteer really did have a preference.
- b. If the volunteer truly wanted to convey a neutral position regarding the two policies, it would have been more effective to have not displayed personal feelings through the head movement.

- c. Non-verbal communication also includes such subtle signals as facial expressions.
 - (1) For example, if you are saying things are fine, but frowning while you say it -there's another mixed message. Your listener may be confused about what is true for you.
 - d. While you don't need to focus on your non-verbal communication, it is helpful to be aware of it. Ask yourself from time to time, "Is my non-verbal message consistent with my verbal message?" Messages that are clearly communicated both verbally and non-verbally are the most powerful.
5. In summary, effective communication involves a transfer of ideas and concepts. Therefore, both the speaker and the listener play important parts in the process. You cannot "send" an idea to someone who cannot "receive" it. Many barriers can block effective verbal communication, but we can anticipate and address these barriers when they arise.

EFFECTIVE VERBAL COMMUNICATION INVOLVES:

Good delivery

Volume - not too loud or too soft

Clear speech

Moderate pace - not too fast or too slow

Clear language

Minimal use of jargon

Clarifying as you go

A listener who can understand what is being said

Language
Values, etc.
Intellectual ability

Consistent non-verbal communication

INTERVIEWING SKILLS

Helping people explore their insurance needs or understand their coverage involves considerable skill in obtaining the necessary information. Each advisor has these skills to varying degrees. You may not have recognized them because somewhere along the line, you developed them without any specific focus. Nonetheless, an effective counselor demonstrates a variety of skills that makes the task easier for both the advisor and the one needing assistance. Interviewing skills are like tools. The more tools you have, the more likely you will be able to accomplish the specific tasks that arise. Sometimes when you try out a new tool, it might feel uncomfortable because it's not familiar. Keep practicing and it will become easier.

ACTIVE LISTENING - Often, discussions about communication focus on talking, but if communication is a process of transferring information, then clearly one half of each transaction must be listening. Active listening is a term used to describe the process of paying attention to hearing and understanding what you are being told. It includes letting the other person know you are listening.

ASKING OPEN AND CLOSED QUESTIONS - There are basically two types of questions used in interviews - open and closed. Their differences relate to the anticipated answer.

- a. A closed question generally asks for a simple yes or no, or for very specific information such as age, address, etc. It is helpful to use closed questions when you want specific facts. However, if the person giving information tends to wander or tell you much more than you need to know, closed questions can help you get focused.
 - (1) Other examples of closed questions include:
 - "Are you currently receiving social security?"
 - "Are you currently married?"
 - "What is your street address."
- b. An open question leaves room for the answer to be general, descriptive, and complex. It is helpful to use open questions to gain initial information about what a person is feeling or thinking, about the history of a situation or about a complex circumstance that cannot be described simply. An open question such as, "What concerns about insurance brought you here today?" will usually help you understand the issues more quickly than a series of closed questions. (Closed questions can get the same information. Example: Q: "Do you have concerns about insurance?" A: "Yes." Q: "Is it about Medicare supplement or long term care?" A: "Medicare supplement.")
 - (1) Other examples of open questions include:
 - "How do you currently pay for health care?"
 - "What resources are you likely to use?"
- c. There are appropriate times for both kinds of questions, because they serve different purposes. Choosing when to use a particular kind of question can save time and frustration for both you and the senior you are assisting.

CLARIFYING - Clarifying questions are used to ensure that you are understanding what the other person is telling you. They may be used

to check that you heard correctly, or to confirm that you are both talking about the same thing.

- a. A common problem in communication is the failure to ensure that both people share an understanding of the subject matter. The less we assume that we know what the other person is saying, the better our communication will become.
- b. Examples of clarifying questions are:
 - "Are you referring to this new policy, when you say that, or to your old policy."
 - "Was it your doctor who said this or the insurance company?"
 - "They told you this illness would be excluded?"
 - "I'm sorry, did you say 'would' or 'would not' do that?"
- c. **Remember, you won't be helpful to anyone if you base your assistance on what you assume the person means. If you have any questions, it's okay to ask them for clarification.**

PARAPHRASING - Paraphrasing is another technique to ensure that you understand what you are being told. You accomplish this by rephrasing the information and asking the person if it is accurate. Summarizing is another techniques that allows you to keep checking on the accuracy of your conclusions.

- a. Examples of paraphrasing include:
 - "In other words, your income changes from season to season."
 - "It sounds like you are worried that the same thing might happen to you. Is that right?"

FOCUSING - Focusing is a technique for directing conversation back to the matter at hand. Basically, it involves acknowledging the other person's concerns and then directing them back to the issue. Often just

acknowledging someone's frustration or concern is enough to allow them to move on to other areas of discussion.

- a. Examples of focusing statements are:
"I understand that it can be frustrating to deal with those office managers, but let's see what we can sort out with these polices."
"It is difficult to get around, isn't it?" Now, what was the question you had about this insurance?"

CHECKING - Checking to see if the other person is hearing and understanding you is critical to effective communication. Several factors can contribute to a breakdown in the communication here. These range from difficulty hearing to unfamiliarity with the terms you are using.

- a. Sometimes there are visual cues to alert you to the possibility that you are not being heard or understood. Sometimes, however, there will be no clue that there's a problem.
- b. It is helpful to ask for confirmation that your message is getting through.
 - (1) If you are doing something as specific as giving directions - or agreeing that the person will follow through with some particular task, it is appropriate to ask them to repeat the instructions.
 - (2) Other times, you may just want to check by asking if they understand.
- c. Examples of checking might be:
"Now that was pretty complicated, do you see the difference between the Medicare approved charge and your doctor's actual charge?"

"Just to be sure I did that right, could you say back to me those directions to the Social Security Office?"

"You look puzzled. Would it be helpful if I went over that again?"

- d. As you can see, there are many ways to help ensure that we are communicating effectively. The examples may seem exaggerated or may sound too formal because they are not occurring in the context of a conversation, but they represent processes that people use all the time.

COUNSELING GUIDELINES

1. It is important to treat people with respect and concern. This means that you must be non-judgmental in your interactions. People may discuss their attitudes regarding doctors, hospital, the government, insurance companies, welfare and many other subjects as they explore their insurance needs and coverage with you.
2. You may or may not share their views. It serves little purpose to get involved in a discussion of your differing views. Unless you are specifically asked for your view on an issue, your beliefs should not be part of the information-sharing process. Even when you are asked specifically for how you feel about a specific action, be careful!
3. Decisions about health care should reflect the individual's beliefs and values, **NOT THE COUNSELORS**.
 - a. It might be helpful to say, "Those kinds of decisions must be personal. There are many views. I believe we all need to decide what fits us personally."
 - b. It is not helpful in SHINE counseling to relay a message that others must view matters in the same way you do.
4. Confidentiality - The discussion of health insurance often involves covering such topics as personal health history and financial circumstances. These are both considered by many to be very personal subjects and require trust that the information will remain confidential.
 - a. It is critical that such confidence not be betrayed; apart from your Regional Coordinator, you should not discuss the particular details of their case with anyone else without the client's permission.

- b. It is inappropriate to discuss the circumstances of a client you counsel with anyone (except the Coordinator) unless you have specific permission from your client to do so. The client should sign the Authorization to Release Information Form before you make contact with any party, e.g., insurance entities or carriers.
 - c. The setting of the interviews should provide adequate privacy to allow for safe sharing of personal information.
 - d. If there are several other persons present or you want to include a volunteer trainee in a session, ask for permission from your client to have others listen in. Do not assume that such inclusion is agreeable to the person seeking assistance. Promptly bring reports of any privacy breaches or problems to your Regional Coordinator.
5. Empathy - It is particularly helpful to be empathetic in your SHINE work with seniors. To be empathetic is to be understanding and sensitive in your interactions.
- a. Often, people do not investigate their insurance needs until a specific need or crisis occurs. This means that many people are seeking assistance from a SHINE counselor at a time of emotional distress and financial anxiety.
 - b. While you are not expected to provide personal counseling, people will see you as informed and helpful, and may confide considerably more personal information than needed or helpful in your SHINE role. It is important to limit your involvement to the appropriate areas of discussion. You can do this in a warm and responsive manner.
 - c. Being responsive to someone's distress does not necessarily require that you will "fix" the problem. Sometimes people just need to be able to express their sadness or their anger to someone who can

listen. It is not helpful to tell people to "stop feeling sorry for themselves", or that they have grieved someone's death "long enough", or similar judgmental statements.

6. Re-focusing the Conversation - It is appropriate to acknowledge a client's feelings and to re-focus the conversation, or refer to the community resource that can handle the issue they are focused upon.
 - a. You might say something like: "It is clear that you still have strong feelings about this. Would you like to talk to someone who could be more helpful with that?" or "Would you like to postpone our examination of these policies until later or would you rather get back to work on them now?"
 - b. Remember, the specific words are not as important as the message that says you respect their right to have their own beliefs and feelings. You do not need to agree with them nor "take care of" their personal problem to give that message.
7. Information and Referral - SHINE volunteers who are familiar with community resources are often able to direct the client to a resource who can handle the secondary concerns which are troubling a client. It is always appropriate to refer a client to the community resources that can assist them with their particular non-health insurance related problem area. Remember to educate your clients about the comprehensive services available from the outreach worker or information specialist of the member agency where you work as a SHINE counselor.

SHINE COUNSELING GUIDELINES

1. **Never make clients' decisions for them.**

- a. In particular, don't tell a person to buy or not to buy supplemental health insurance, or join or not to join any particular health maintenance organization. Our purpose is to give as much information as possible so a person can make an informed decision. You should respect the person's intelligence.
- b. Many of your clients may ask what you would do. Answer this question by exploring the options available. Review the pros and cons of each option and resist the temptation to say, "If I were you, I'd..."

2. Treat the client like a friend you would want to help.

- a. One purpose of peer counseling is to remove communication barriers. Treat all clients with courtesy, respect and empathy. Not only is such an attitude helpful and appropriate, but it will also improve communication.

3. Make sure you understand the question before you give an answer.

- a. Make sure the person is asking about Medicare, supplemental health insurance or HMOs. It will not always be immediately apparent. Listen carefully for clues. Make sure you answer the question being asked. You will become better at this with practice.

4. When in doubt, check it out!

- a. If you aren't certain about the accuracy of information you want to give, check it out first. You aren't expected to know everything. You have SHINE staff and written materials to use as resources.
- b. Implying that something is fact, when it may not be so, can be very dangerous. **If you do not know the answer to a question, be sure**

to tell your client that you will look into it and that you will call later with the answer. . .

5. **Don't tell someone that his or her problem will be resolved** by a court, another agency or by the Insurance Commissioner's office. Never tell clients that their claims will be resolved to their satisfaction because that is not always possible.
6. **Be alert to time limits.**
 - a. If a client indicates that he or she is unhappy with a Medicare decision and is interested in challenging it, be sure to explain the time limits that are noted on the Explanation of Medicare Benefits (EOMB) statement. Failing to be attentive to these limits could result in a person's loss of appeal rights.
7. **Before client leaves, make sure both of you know if further contact is needed.**
 - a. Determine if the person is to bring something to you or call you with information. Confirm what, if anything, you have agreed to do for the person.
 - b. Unless the client has to call or return with further information, your contact will usually be completed at the time of your counseling session.
8. **No job is finished until the paperwork is done.**
 - a. Complete an intake form or telephone log for each counseling contact and submit all monthly reports in a timely manner. The information that you are required to take is important for the assessment of the individual's problem. Also, it is vital for analyzing the problems of the senior population as a whole. In

addition, your supervisor shall look at the intakes to confirm your understanding of the health insurance options available. Each month, finish your monthly report and send it, along with all your closed intakes, to your Regional Coordinator.

9. All client information is confidential.

- a. Everything a client tells you is in confidence. Never discuss or share information about a client's case with friends or relatives. Cases may only be discussed with SHINE staff. Contact to outside organizations on behalf of client should only be initiated after your client has signed the authorization form.

COUNSELING GUIDE for SUPPLEMENTING MEDICARE

THE SHINE COUNSELOR NEVER RECOMMENDS THAT CLIENTS BUY A PARTICULAR POLICY!!! THE COUNSELOR'S ROLE IS STRICTLY TO HELP CLIENTS DEVELOP ACCURATE, OBJECTIVE INFORMATION TO HELP THEM MAKE SOUND DECISIONS FOR THEMSELVES.

COUNSELING STEPS

- STEP 1. QUALIFY THE CLIENT - CHECK ELIGIBILITY FOR PUBLIC BENEFITS PROGRAMS
- STEP 2. EXPLAIN MEDICARE
- STEP 3. DISCUSS COSTS VS. BENEFITS FOR MEDICARE SUPPLEMENTS, RETIREE PLANS, OR MANAGED CARE OPTIONS
- STEP 4. ANALYZE THE CLIENT'S CURRENT COVERAGE, IF ANY, USING THE MEDICARE SUMMARY AND THEIR PLAN'S OUTLINE OF COVERAGE.
- STEP 5. RELAX. DON'T WORRY IF YOU CAN'T ANSWER EVERY QUESTION. TELL THE CLIENT YOU WILL CALL BACK WITH THE APPROPRIATE INFORMATION.

STEP 1: QUALIFY THE CLIENT

Find out what sorts of assistance he or she may already be receiving or may be eligible to receive. Ask these questions:

-- Is the client 65 or older?

--Is the client under 65; but on Social Security disability?

--Is the client's monthly income less than \$665, and do his or her other resources total \$2,000 or less (home, car and household items are exempt from this calculation) or in the case of a couple, \$884 with other resources totaling \$4,000 or less? If yes, then discuss his/her potential eligibility for Medicaid, QMB or SLMB. If they are interested in applying, refer him or her directly to one of the three MassHealth Enrollment Centers for an application for Medicaid, QMB and SLMB eligibility. If qualified for Medicaid, the client need not purchase Medicare supplement or long-term care insurance. If qualified for QMB, the individual would only need prescription drug coverage which they may get from a medigap plan or HMO with drug coverage. **These figures change annually.**

--If the client has confirmed with a MassHealth Enrollment Center (Medicaid office) that he or she was enrolled in Medicaid prior to purchasing a Medicare Supplement, then this person should be advised of his or her right to a refund of premium from the medigap insurer. Also, they could report this violation of the law to the Division of Insurance. If they want to file a complaint, then get the name of the insurance company, the policy number and the name of the agent who sold the policy. Give this information immediately to the Consumer Services Unit at the Massachusetts Division of Insurance.

--If the client is a retired federal employee, state retiree, miner or railroad worker, he or she may be covered by a special medical plan which takes the place of Medicare and Medicare Supplemental insurance. Connect them with the federal or state office that handles retiree health plans for this group. Some clients may qualify and receive benefits from a special medical plan (because they belong to one of the above groups) while being eligible for Medicare.

--A client may be eligible for medical treatment through the Veteran's Administration, Marine Hospital or Bureau of Indian Affairs. Verify whether or not these options are available.

--A client's spouse may be employed and have access to the employer's group health insurance plan. The retired spouse could be covered as a dependent on the working spouse's plan while the worker is actively employed.

--Ask about the client's health. This affects the type of insurance benefits or health delivery system he or she may want to consider.

--Ask the client to consider how much insurance he or she can comfortably afford, given all of life's other living expenses.

STEP TWO: EXPLAIN MEDICARE

Use the Medicare Part A and Part B chart to show clients what Medicare will and won't pay.

--Unfilled gaps which should be considered:

1) Under Medicare Part A:

- a. hospital deductible
- b. custodial nursing home care
- c. inpatient days beyond Medicare periods of coverage.

2) Under Medicare Part B: doctor and medical services.

- a. difference between Medicare's payment and doctor's bill
- b. explain that Medicare's payment for Part B providers allowed charges, the maximum Medicare will pay, may amount to only 65-80% of the total bills. In some cases, the client must pay for excess fees in addition to the 20% of approved charges which Medicare does not pay.

- Explain that Medicare is not designed to pay for everything.
- Medicare enrollees pay a monthly Part B premium.
- Medicare does not provide coverage while traveling abroad
- Medicare does not pay for out-patient prescription drugs.

STEP THREE: DISCUSS COSTS VS. BENEFITS FOR THE VARIOUS SUPPLEMENTAL OPTIONS TO MEDICARE

While the decision to buy insurance always rests with the client, some clients have not had the opportunity or the information to do a systematic analysis of their health insurance needs versus the benefits they are likely to receive from a given policy.

- A. Most gaps in Medicare coverage can be filled by purchasing one Medicare supplement policy, maintaining retiree benefits or enrolling into a Medicare Managed Care plan.
- B. Complete coverage of all gaps in Medicare benefits can be expensive. Has the client assessed the likelihood of needing various types of coverage not already covered by Medicare?
- C. Encourage the client to work with you, the SHINE Counselor, to assess each health care option's costs versus the option's benefits based upon his or her own needs for medical services.

STEP FOUR: ANALYZE THE CLIENT'S CURRENT COVERAGE, IF ANY, USING THE MEDICARE COVERAGE SUMMARY AND OUTLINES OF COVERAGE

NEVER ATTEMPT TO ANSWER QUESTIONS ABOUT A CLIENT'S CURRENT PLAN OR POLICY UNLESS YOU HAVE THE OUTLINE OF COVERAGE AND POLICY (WITH

MATCHING POLICY NUMBERS) IN YOUR HANDS. STOP THE INTERVIEW HERE AND RESUME ONLY WHEN YOU HAVE THE POLICY IN HAND!

--Use Outlines of Coverage (find the one specific to the policy of the client.)

--Be sure you have the client's actual policy to check against the Outline of Coverage that you have the correct Outline of Coverage for this policy. Check:

- a. exact name of the insurance company
- b. form number (policy number)
- c. name (type) of insurance contract
- d. policy riders for additional coverage

--Be aware that insurance companies may be selling several very similar policies in this state at the same time; for example, one company may sell group and non-group Medicare supplements under a similar brand name. The seemingly subtle differences among them can be very important to a particular client. Be careful.

--Find the **DISCLOSURE FORM** for any new policy being considered. Agents are required by law to leave this with the client at the time of sale of the insurance policy.

--Use the SHINE Comparison of Policy forms to compare policies. Transfer information from the Outline of Coverage to the "Your Insurance Pays" column of the appropriate comparison form.

--Use the completed form to assess what the policy offers when combined with Medicare.

--If the client has more than one policy, repeat this process for each policy to determine overlapping coverage.

STEP FIVE: RELAX

Remember, you've been trained and know much more about Medicare, Medicare supplement and long term care insurance than your clients and most of the rest of the population.

If you cannot answer a question, take the client's name, telephone number, policy number (if applicable), write down the questions and tell the client you will get back to him or her with an answer as soon as possible. And, do not hesitate to call your Regional SHINE Coordinator for assistance.

--The only blunder is to give out wrong or prejudiced information. It's okay to say you don't know the answer to a client's question. This field of insurance is very dynamic and complex. No one knows everything about every policy or managed care plan.

THE COUNSELOR'S RECORD KEEPING RESPONSIBILITIES

On the following pages are copies of the forms, with accompanying instructions, you will use in your counseling. Make copies as needed at your counseling site. Your Regional Coordinator can explain answer any questions you may have on when and how to use these forms.

Besides these tools, the SHINE Coordinators, SHINE State Staff and numerous offices of federal and state programs have public information brochures which are helpful to you and/or your clients. Your SHINE regional coordinator can provide you with more details about these materials and where to get them.

SHINE PROGRAM COUNSELING RECORD FORMS

SHINE TELEPHONE LOG

Often, SHINE clients will field telephone calls from clients who have easy questions that can be handled over the telephone. Our goal is to provide face to face access to a trained counselor who can explain Medicare and Medicare supplements, HMO benefits, long term care insurance or public benefits. etc. However, some callers just need basic factual information or request printed information.

1. For this type of call, please record the caller's name and phone number on the Telephone Log. Then, mark off every subject that you talked about with them. If you discussed other material, please write that in the miscellaneous area.
2. As a reminder for yourself, it is useful to write in brief notes what action you took on their behalf. For example, "phone number for SSA", or "referred to Medicaid office for QMB - offered to help with application", or "Appointment made-6/17/94, 11AM." Also, It is useful to write down the date and time whenever you tried to return a call but received no answer. Later, you can show that you did try to return the call.

SHINE PROGRAM FACT SHEET

Each face to face counseling session should begin with you explaining who you are, what your role is, what the SHINE Program services are, the limits to your functions as a SHINE Counselor, and the responsibility of the client to act as the decision maker. These roles and responsibilities are spelled out on the "Fact Sheet About What We Do" Form.

SHINE AUTHORIZATION FOR RELEASE OF INFORMATION FORM

The Authorization Form contains an authorization to release information to a SHINE counselor who works on behalf of the client. This Authorization Form must be signed by the client so external agencies may release personal and confidential information about the client to the SHINE counselor.

1. If you determine you will need to contact outside agencies to assist a client, have the client read, sign and date an Authorization for Release of Information form.
2. Clip the signed Authorization Form inside the client's file. Sometimes, a copy of the authorization to release information will be requested of you before someone releases information to you. When that occurs, copy the Authorization Form, mail it to the contact person, and call upon them one week later.
3. It is all right if a client wants to limit the effective dates on the Authorization Form. For example, they may want the release to last for one month only. In any event, the Release should not last for more than one year.
4. Once the case is closed, write "VOID" across the Authorization Form and attach it to the closed intake form. These shall be sent on to the Coordinator with your monthly counseling activity report.

SHINE CLIENT INTAKE FORM

Please use an intake form for cases in which you engage in more than general questions and answers; for simple exchanges, you may use the telephone log to record that activity. Refer to the Counseling Intake Form Instruction sheet, attached.

1. Try to write down the dates and amount of time you have spent on cases so you can report the total time spent counseling. Often, a case will involve multiple meetings between you and the client. It is very important to give an accurate picture on how essential your counseling and assistance services are for elders!

2. Usually, a client's case will be settled in the month you meet with them. Once the first case is closed, if the same client should return to you a few months later, then you should use a fresh intake form. Their address or coverage could have changed since your first meeting.

3. Clip the intake form in the client's file along with the client's authorization form. Once the case is closed, you will need to send the closed intake form and the voided authorization form in your monthly activity report to your SHINE Coordinator.

THANK YOU FOR YOUR ATTENTION TO THESE DETAILS!!

SHINE - MONTHLY ACTIVITY REPORT

Every counselor must complete a Monthly Activity Report and send it to the Regional Program Coordinator.

1. Both the Telephone Log and the Counseling Intake Form are sources of information for completing the Monthly Activity Report. Aggregate the essential data from each telephone log entry

and closed Intake Form and record the total units of activity under the different categories on the Monthly Activity Report Form.

2. Your summary of the health benefit issues you worked on will help your Coordinator to supervise your work and to develop training for other counselors within your region. So please write freely and don't be shy!

3. Please send your Monthly Report form to the Coordinator by the 10th of each month. Include in the same envelope your closed intakes and telephone logs. There is no need to store records with personal data about clients at the member sites. So, clean out your files every month, return documents to your clients, complete the monthly report as required, and send all closed intakes with voided authorization forms to your regional SHINE Program's central office.

YOU ARE HELPING ELDERS TO ACHIEVE GREAT FINANCIAL SAVINGS! YOUR ACHIEVEMENTS NEED TO BE KNOWN SO THE PROGRAM CAN CONTINUE TO JUSTIFY ITS REQUESTS FOR CONTINUING FUNDING. THANK YOU.

LOG

[illegible]

Serving Health Insurance Needs of Elders (SHINE) Program

Fact Sheet About What We Do

SHINE Counselors provide information, counseling and assistance to people with questions about Medicare, claim forms, Medicare supplements ("Medigap"), Health Maintenance Organizations (HMOs) with Senior Plans, long-term care insurance, Medicaid, and various other health insurance options that affect Medicare beneficiaries and senior citizens.

SHINE Counselors undergo a 6-day training by Elder Affairs staff and are tested and certified before they may volunteer as a SHINE counselor.

SHINE volunteers cannot tell you what to do. For example, they cannot tell you to purchase or cancel a certain insurance policy or HMO membership. SHINE counselors can help you to learn the right questions to ask and facts to consider while looking for the most suitable health insurance coverage for you.

SHINE volunteers frame their questions and give information based upon information you supply to them. Try to tell them as much of your concerns as necessary so they can help you in the most appropriate manner. In the end, all final decisions regarding your health insurance can only be made by you.

Lastly, SHINE staff have been trained to keep all that you say and share with them confidential. On the back of this page there is a summary of how the SHINE Program keeps your personal information safe and confidential. Please read it so you will understand we are serious about keeping your information private.

The SHINE Program is sponsored by the Massachusetts Executive Office of Elder Affairs in order to provide health benefit information, counseling and assistance to senior citizens in Massachusetts. Medicare beneficiaries of any age can also rely upon SHINE Counselors to provide accurate and unbiased information about with Medicare, Medicare supplemental insurance or Health Maintenance Organizations with Medicare plans.

SUMMARY OF CONFIDENTIALITY PROCEDURES
Used by Local SHINE Counselors
and Regional Coordinators

All SHINE Counselors and Regional SHINE Program Coordinators are bound by strict rules of confidentiality. Any personal information we collect from you must be essential data which is needed to provide accurate and relevant health benefits information, counseling and assistance.

The SHINE Counselor stores all active counseling files on the premises of the counselor's host agency. No one else at the host agency site is allowed to see SHINE Intake Forms. In fact, the Regional SHINE Coordinator is the only other person who will see the information written on a client's Intake Form. The Coordinator reads Intake Forms in order to supervise the work of the SHINE Health Insurance Counselor and collect non-personal statistics about health issues of concern to elders generally. The SHINE Coordinator must store all Intake Forms in a safe storage area.

When your counseling sessions are complete, the SHINE Counselor will return all original paperwork to you and destroy any copies. The SHINE Counselor will only keep the Intake Form and a voided copy of your Authorization to Release Information Form. Then, at the end of each month, the Counselor will mail all closed case files to the Coordinator for supervision and storage.

The Regional Coordinator must store each client's Intake Form at the Regional Program's central offices listed below. Every July, these regional files are examined for the purposes of destroying all Intake Forms which are more than 7 years old.

If you have any questions or complaints about the SHINE program's methods of collecting or holding data, please send your comments in writing to the Regional SHINE Coordinator, _____, at

The Coordinator will respond to all questions promptly and shall investigate any complaint within 30 days.

Thank you for the opportunity to serve you!!!

TRAINING ON CONFIDENTIALITY PROCEDURES FOR SHINE PROGRAM STAFF

A client can only truly give **informed consent** for providing personal data to a SHINE counselor if the SHINE counselor has told the client, in an understandable manner, that the SHINE staff will not collect, store or use any personal data other than what is essential for performing their SHINE duties, **and** the client understands.

Personal data can be any piece of information about a person that relates to their care, financial support, medical services, social status, psychological status, or physical characteristics. It is any kind of information about a person which, if revealed, could readily be associated with the person. A counselor could break the rule of confidentiality by using descriptions about a client's social situation, physical impairment, medical condition, family structure, address or even incomplete pieces of their name. Also, a client's confidentiality would be violated if case files are not managed properly, according to the following guidelines.

As a SHINE Counselor, whenever you engage in personalized counseling sessions and use an Intake Form to record relevant information for your work, you should tell each client :

- the information they provide must be used and stored in a manner that limits access to only those persons who have a need to see the information in order to perform the SHINE services of direct counseling, education, assistance on claims, and program monitoring and supervision.
- information will only be used to work on medical claims or to form the basis for counseling.
- where and for how long the information will be stored:
 1. Client records are kept at your counseling site until the case is closed. Then, all documents belonging to the client are returned to him/her. Only the Client Intake Form and the voided Authorization Form for Release of Information are mailed to the Regional Coordinator for central storage and supervision.
 2. Each July, the Regional Coordinator should review the files at your counseling site to be sure you have kept your files in an orderly manner. Only open case files will be retained into the new year. The Regional Coordinator

shall review the central files every other year and destroy any closed Intake Form that is more than 7 years old.

- Assure the client that any SHINE staff who may see parts of the intake and case information are bound by the same rules of confidentiality.
- Offer to answer any inquiries concerning methods of holding data and the type of data that is kept.
- Indicate that all clients have the right to object to the methods of collection, maintenance, accuracy or use of the information by sending their comments in writing to the regional coordinator. She/he will respond to any complaints within 30 days.
- Give the Summary of Confidentiality Procedures Used by the SHINE Program to every person who is counseled using and Intake Form. For your convenience, we suggest printing the Summary of Confidentiality Procedures form on the back of the SHINE Program's "Fact Sheet About What We Do".

Authorization Form for the Release of Information to a SHINE Counselor

The Serving Health Information Needs of Elders (SHINE) Program is a health benefits information, counseling and assistance program administered by the Executive Office of Elder Affairs. It provides free and confidential counseling on health insurance options for senior citizens.

I authorize _____, of _____,
_____(address), to inquire and receive
information on the following: *(One or more may apply)*

- Claims for services submitted by doctor/supplier: _____
- Medicare claims information: _____
- Health insurance coverage issued by: _____
Policy/Certificate Number _____
- Deductible information for year: _____
- Explanation of Medicare Benefits dated: _____

Date of Service	Doctor/Supplier/Hospital
_____	_____
_____	_____
_____	_____

- Other matter described here: _____

I authorize the release of this type of information to the person named above for the following period of time:

From _____ to _____

Please retain this Authorization Form for Release of Information in your files for future inquiries from the person named above.

Signature of SHINE Client

Street

City / State / Zip Code

Date

SHINE PROGRAM INTAKE FORM

COUNSELOR NAME: _____ **Date:** _____

COUNSELING SITE: At Site: _____ (_____) In Home: _____ By Phone: _____
(abbrev. name of member agency)

CLIENT NAME: _____ **Phone:** _____

Address (street, city, zip) _____

Birth Date: _____ **Soc.Sec.#:** _____ **Medicare #** _____

NEW CLIENT OR REPEAT CLIENT:

_____ **First Visit to SHINE by client** (*since last July 1st*)

_____ **Repeat Client** (*met with SHINE Counselor previously since July 1st*)

IS RELEASE OF INFORMATION AUTHORIZATION FORM NEEDED? YES NO

(If yes, store in client's file for future use.)

SUMMARY OF QUESTIONS OR PROBLEM NEEDING ASSISTANCE: _____

OPTIONS DISCUSSED:

WHAT HEALTH INSURANCE DOES CLIENT HAVE? (*Check all that apply*)

_____ **Medicare Part A** **Effective Date:** _____

_____ **Medicare Part B** **Effective Date:** _____

_____ **Medicaid(communit)** _____ **Medicaid (LTC)** _____ **QMB** _____ **SLMB**

_____ **Medigap/Supplement** _____

_____ **HMO/Managed Care** _____

_____ **None**

_____ **Employer-Sponsored for Self or Spouse** _____

_____ **Continuation of Group Health Coverage from Past Employer ("COBRA")**

_____ **Retiree Health Insurance** _____

_____ **Long Term Care Insurance** _____

_____ **Federal/State/Municipal** _____

_____ **Veterans**

_____ **Major Medical Health Insurance** _____

COUNSELING TOPICS DISCUSSED:

_____ Medicare _____ Medigap/Supplement
_____ HMO/Managed Care _____ Long Term Care Insurance
_____ Medicaid/QMB/SLMB _____ Medicaid (LTC) _____ SSI
_____ Federal/State/Municipal _____ Employer-sponsored
_____ Free Prescription Drugs _____ Hospital Free Care
_____ Other Health insurance(specify) _____
_____ Billing/Claims assistance _____ Potential Sales or Marketing Abuse

REFERRAL and FOLLOW UP:

Client Requested Assistance to Contact (Referral): _____

Referred to: _____
(print name of person or agency client was referred to)

Is more work by SHINE Counselor needed? Yes _____ No _____

If yes, date for next appointment: _____

FINANCIAL BENEFIT TO CLIENT

Financial savings based upon actual savings:

\$ _____ Claims filed for Medical care or Prescription Drugs
\$ _____ Correcting Medicare Denials and/or Appealing Medicare Denial
\$ _____ Hospital Free Care
\$ _____ Free Prescription Drug Program
\$ _____ Other

Financial Benefits based upon estimated annual savings:

\$ _____ Insurance premium cancellation
\$ _____ Insurance premium reduced
\$ _____ Medicaid eligibility for community care
\$ _____ QMB/SLMB eligibility
\$ _____ SSI (Supplemental Security Income) eligibility

TOTAL:\$ _____

TIME SPENT: Hours _____ Case Closed?: YES _____ NO _____

COMMENTS(Counselor/Coordinator): _____

REVIEWED BY COORDINATOR (signature): _____ **DATE:** _____

**SHINE PROGRAM
COUNSELING INTAKE FORM
INSTRUCTIONS**

COUNSELING SITE: Identify the location or route (telephone) of counseling.

CLIENT INFORMATION:

Birthdate is provided, rather than age, so that if a client returns at a later point, the age information is accurate (e.g. if person reports being 64 years old but returns at age 65).

Social Security and Medicare Numbers are often needed by the counselor while assisting a client. This information would not be released to anyone. It may be helpful if you had to call Social Security or the Medicare Carrier for a client. However, a client is **not required** to provide this information.

TYPE OF CONSULTATION is defined in one of the following ways:

First visit= a new client seeking help on any issue or problem who has never participated in the SHINE program before;

Repeat/New issue = a client who returns for assistance within current year, beginning last July 1st, for assistance with a new issue or problem.

CLIENT RELEASE OF INFORMATION AUTHORIZATION FORM SIGNED?

The RELEASE FORM provides you with permission to speak with insurance companies (including the Medicare and Social Security) on their behalf. Keep a copy on record in case you need to mail it to an insurer or provider. Once the need for counseling ends, void out the Release Form by writing "VOID" across the form.

WHAT HEALTH INSURANCE DOES CLIENT PRESENTLY HAVE?

Be sure to inquire about all coverage and check all that apply. You could write the policy number(s) in the Counseling Summary section.

COUNSELING SERVICES PROVIDED:

Be sure to check all topics that were discussed. If you explain the features or benefits of a policy or policies, or compare various benefits available within or across a health insurance option, each type of policy should be identified and counted as a "counseling service". The term "Billing/Claims" includes explaining or sorting bills or assisting in claims filing, and should also be counted as a "service" provided. "Closed" refers to the date the case was closed or resolved.

SUMMARY OF COUNSELING SESSION / SUMMARY OF QUESTIONS OR PROBLEMS PRESENTED:

You should provide a **brief** summary of the counseling session including the amount of time spent. Time spent should include all of the time the volunteer works **directly** on assisting the client with their problem/inquiry. For example, if a Counselor spends one hour counseling a client on a claims filing problem, then spends one hour sorting bills after that client has left the session, this should be recorded as two hours spent. If you have to spend fifteen minutes conferring with your Coordinator regarding a case, that time should also be counted as time spent.

REFERRAL AND FOLLOW-UP:

This allows SHINE to track referral needs of client and monitor the outcome. It also insures that clients don't fall through the cracks if follow-up is necessary.

FINANCIAL BENEFIT TO CLIENT - TOTAL DOLLAR AMOUNT

We must try to determine if any financial savings to the client have occurred. In some cases it will be extremely difficult to know definitively whether or not a client actually acted upon decisions made to cancel or switch a policy or seek reimbursement from a third party. Therefore, this section relies on the reasonable assumptions of the client's future actions. If at all possible, include the approximate financial benefit to the client as a means to demonstrate the cost-effectiveness of the SHINE Program.

Record the financial benefit from filing insurance claims for medical care and prescription drug reimbursement, or seeking Medicare reimbursement on past services rendered or filing an appeal other insurance denials, should be calculated on the amount of the claim or appeal.

Hospital free care or any other medical free care (e.g. retroactive assignment or full waiver of a medical bills) should be calculated for the full amount applied for. Free prescription drugs should be calculated on the amount of prescription costs at a local pharmacy and calculated for the amount of prescriptions the client will receive.

Insurance premium cancellation or reduction should be estimated on an annual basis.

Use the attached chart to record the estimated financial benefits associated with enrolling into a Public Assistance program such as Medicaid, SSI, QMB and SLMB. First, Calculate the financial benefit on a monthly savings basis and then convert it to an annual benefit.

COMMENTS

Either Counselor or Coordinator may want to add information about problems they encountered while counseling or assisting this individual or lessons learned while assisting this client.

1996 ANNUAL FINANCIAL SAVINGS FOR SHINE MONTHLY REPORTS
MEDICAID, SSI, QMB, and SLMB

ITEMS	MEDICAID	QMB	SLMB	SSI
MEDICARE PART B PREMIUM	\$510.00	510.00	510.00	510.00
PART B DEDUCT-IBLE	\$100.00	100.00	DNA	100.00
PART A DEDUCT-IBLE	\$736.00	736.00	DNA	736.00
COINSUR- ANCE FOR MEDICARE SERVICES	\$100.00 OR ACTUAL, IF KNOWN	100.00 OR ACTUAL, IF KNOWN	DNA	100.00 OR ACTUAL, IF KNOWN
OTHER MEDICAL BILLS x 12	ACTUAL, IF KNOWN	DNA	DNA	ACTUAL, IF KNOWN
DRUGS	ACTUAL, IF KNOWN	DNA	DNA	ACTUAL, IF KNOWN
MEDIGAP INSUR- ANCE PREMIUM FOR ONE YEAR	ACTUAL, IF MEDIGAP POLICY IS DROPPED	ACTUAL, IF MEDIGAP POLICY IS DROPPED	DNA	ACTUAL, IF MEDIGAP POLICY IS DROPPED
FOR SSI ONLY - ADD'L MONTHLY INCOME	DNA	DNA	DNA	ACTUAL, IF KNOWN
	\$1446 + _____	\$1446 + _____	\$510 ONLY	\$1446 + _____
TOTAL				

INSP1WU0PW0UL2,12.5,12.5,12.5,12.5,12.5,12.5,12.5,12.5;UL5,40,25,10,25;UL6,35,1

SHINE PROGRAM MONTHLY ACTIVITY REPORT

COUNSELOR NAME: _____ **Date:** _____

NUMBER COUNSELED AT SITES: At Site(s): _____ In Home(s): _____
By Phone: _____

NEW CLIENTS OR REPEAT CLIENTS:

_____ First Visit to SHINE by client (*since last July 1st*)

_____ Repeat Client (*met with SHINE Counselor previously since July 1st*)

COUNSELING TOPICS DISCUSSED:

_____ Medicare	_____ Medigap/Supplement	
_____ HMO/Managed Care	_____ Long Term Care Insurance	
_____ Medicaid/QMB/SLMB	_____ Medicaid (LTC)	_____ SSI
_____ Federal/State/Municipal	_____ Employer-sponsored	
_____ Free Prescription Drugs	_____ Hospital Free Care	
_____ Other Health insurance(specify)	_____	
_____ Billing/Claims assistance	_____ Potential Sales or Marketing Abuse	

FINANCIAL BENEFIT TO CLIENT

Financial savings based upon actual savings:

\$ _____	Claims filed for Medical care or Prescription Drugs
\$ _____	Correcting Medicare Denials and/or Appealing Medicare Denial
\$ _____	Hospital Free Care Pool
\$ _____	Free Prescription Drug Program
\$ _____	Other

Financial Benefits based upon estimated annual savings:

\$ _____	Insurance premium cancellation
\$ _____	Insurance premium reduced
\$ _____	Medicaid eligibility for community care
\$ _____	QMB/SLMB eligibility
\$ _____	SSI (Supplemental Security Income) eligibility

TOTAL: \$ _____ Financial Savings for the Client Resulting from SHINE Counseling

PAGE 2 - MONTHLY ACTIVITY REPORT FORM

TOTAL TIME SPENT THIS MONTH:

Counseling Hours _____

Training Hours _____

Presentation Hours _____

TOTAL Hours: _____

COMMENTS(Counselor to Coordinator):

Please complete this monthly report form, attach all closed intake forms with voided authorization forms, and mail entire packet to the Regional SHINE Coordinator by the 10th of each month.

REVIEWED BY COORDINATOR

(signature): _____ DATE: _____

FREQUENTLY USED TELEPHONE NUMBERS FOR SHINE VOLUNTEER COUNSELORS

SHINE Program Staff at the Executive Office of Elder Affairs

Direct Lines 800-882-2003
617-727-7750

Director x330
Program Specialist x464

Coordinator: _____, Tel: _____

Address: _____

MEDICARE

PART A and B BENEFITS 800-882-1228

Information on Part A and Part B services, EOMBs, doctor's billing limits, and reviews of Medicare denials.

MEDICARE FRAUD AND ABUSE 800-368-5779

To report frauds such as unnecessary billing for services never received, performing unnecessary procedures, or the routine waiver of deductibles or co-insurance amounts. Contact the carrier or intermediary first; if they do not respond to the report, then contact HCFA at above number.

DURABLE MEDICAL EQUIPMENT CARRIER

The Travelers Company 800-842-2052
Fraud and Abuse - DME same as above

HCFA

MEDICARE BENEFICIARY SPECIALISTS 617-565-1232

For assistance with Medicare policy, regulations and information; and assistance with Medicare problems after communication with the carrier.

MassPRO 800-252-5533

For questions about hospital admissions and DRG appeals, Medicare benefits, timing of a hospital discharge, and quality of care concerns of Medicare beneficiaries using Part A services provided by all Part A providers and Medicare HMOs..

MASSACHUSETTS MEDICARE ADVOCACY PROJECT (MMAP) 800-323-3205

Legal staff provide free advice and representation on Medicare appeals and billing concerns to any Medicare beneficiary. Confer with MMAP on any potential wrongful denial of a Medicare benefit.

BOARD OF REGISTRATION OF MEDICINE 617-727-3086

Handles Ban on Balance Billing Complaints as well as complaints about the quality of physician's services.

DIVISION OF INSURANCE

CONSUMER AFFAIRS/COMPLAINTS 617-521-7777

Takes complaints about insurance sales practices or reimbursement problems.
Mail written complaints to: DOI, 470 Atlantic Ave., Boston, MA 02210.

BLUE CROSS/BLUE SHIELD

MEDEX 800-258-2226

617-376-4700

MANAGED MAJOR MEDICAL 800-882-2700

617-376-7500

BC/BS FEDERAL EMPLOYEE PLANS 800-433-7766

MEDICARE SUPPLEMENT INSURANCE OFFICES

AARP - PRUDENTIAL 800-523-5800

Claims 800-523-5880

BANKERS LIFE AND CASUALTY /

Western MA 203-683-0709

Cape Cod 508-759-8901

Framingham 508-820-8301

Claims 312-396-6000

BANKERS MULTIPLE LINE 800-643-9917

BLUE CROSS & BLUE SHIELD

MEDEX 800-258-2226

617-376-4700

TDD 617-956-3801

HARTFORD LIFE INSURANCE CO.

Retired Offices Association 800-247-2192

Assoc. of United States Army 800-882-5707

MUTUAL OF OMAHA 800-995-9163

NEW YORK LIFE 800-995-7445

HEALTH MAINTENANCE ORGANIZATIONS (HMO) WITH MEDICARE CONTRACTS

COMMUNITY HEALTH PLAN 800-344-5682

FALLON 800-283-2556
508-831-0712

HMO BLUE 800-325-2583
Blue Care 65 800-678-2265

HARVARD COMMUNITY HEALTH
First Seniority 800-779-7723

HARVARD COMMUNITY HEALTH PLAN
OF NEW ENGLAND
Care Plus 800-835-5522 x51406

KAISER FOUNDATION HEALTH PLAN 413-256-0151

PILGRIM HEALTH CARE 800-269-9302

TUFTS ASSOCIATED HEALTH PLAN 800-246-2400

UNITED HEALTH PLAN OF NEW ENGLAND 800-448-4481

U.S. HEALTHCARE 800-991-9555

REMEMBER!!! SHINE counselors never endorse insurance products, agents or brokers.

HOSPITAL FREE CARE POOL

DIVISION OF HEALTH CARE FINANCE AND POLICY 617-451-5330

LOCAL HOSPITALS/BILLING OFFICE THAT HANDLES APPLICATIONS:

1. _____
2. _____
3. _____

MEDICARE ADVOCACY OFFICE

Department of Public Health

800-462-5540

617-727-8984

Handles appeal of hospital discharge plan and questions about a Medicare or a Medicaid patient's rights for care and notification before denying coverage. Also handles complaints about home health agencies and nursing homes.

MEDICAID (INCLUDING)

QUALIFIED MEDICARE BENEFICIARY PROGRAM (QMB)

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PROGRAM (SLMB)

GENERAL INFORMATION - eligibility

1-800-841-2900

Questions about eligibility, applications, and medical transportation

DIVISION OF MEDICAL ASSISTANCE - MassHealth Enrollment Centers (3)-

Handles all Medicaid applications - both community Medicaid cases and cases involving long term care in a skilled nursing facility or chronic care hospital, or rehabilitation hospital.

Charlestown LTC Unit

800-322-1448

Taunton LTC Unit

800-242-1340

Springfield LTC Unit

800-332-5545

MEDICAID INFORMATION HOTLINE

617-348-5531

For SHINE counselors only: Answers policy questions about coverage or eligibility and application questions on both community Medicaid and long term care Medicaid.

STATE EMPLOYEES

GROUP INSURANCE COMMISSION

800-548-5000

617-727-2310

Manages health insurance plans for all retired state employees and some retired teachers; also manages all health insurance plans for active state employees.

FEDERAL EMPLOYEES

OFFICE OF PERSONNEL MANAGEMENT

202-606-0125

Contact for assistance with Massachusetts health plan options for civilian federal employees and retirees.

RAILROAD RETIREMENT BOARD

617-424-5790

Provides Medicare materials and information to railroad retirees.

SOCIAL SECURITY ADMINISTRATION

GENERAL INFORMATION (card, pension, SSI) 800-772-1213

LOCAL OFFICES

1. _____

2. _____

VETERANS AFFAIRS

1. Federal - Veteran's Affairs

617-227-4600

2. State Office of Veteran's Services

617-727-3578

Local Municipal Veteran's Agent -

RATING LIBRARY AND OTHER FINANCIAL REPORTING RESOURCES

1. RATING LIBRARY

617-227-2087

The following resources are available in the reference section of any local library. They may also be contacted by telephone, but it may be a toll call and some reporting agencies may charge a fee for their services.

1. MOODY'S INVESTOR SERVICE

212-553-1653

2. DUFF AND PHELPS

312-368-3157

3. STANDARD AND POOR

212-208-1527

4. OTHER: _____

ADDITIONAL TELEPHONE NUMBERS

FREQUENTLY REFERRED BY SHINE COUNSELORS (in alphabetical order)

ADULT DAY HEALTH CENTERS (LOCALLY)

1. _____

2. _____

3. _____

ALZHEIMER DISEASE ASSOCIATION OF MASSACHUSETTS

1. HEADQUARTERS

617-494-8433

2. LOCAL ASSOCIATIONS/SUPPORT GROUPS

(BLINDNESS)

MASS COMMISSION FOR THE BLIND 617-727-5550

AMERICAN FOUNDATION FOR THE BLIND 800-AFBLIND

BOSTON AID TO THE BLIND 617-323-5111

CITIZEN'S INFORMATION SERVICE 800-392-6090
Secretary of State

DEAFNESS

MASS. COMMISSION FOR DEAF AND HARD OF HEARING
Voice/TTY 800-882-1155

DEAF TELEPHONE RELAY 800-439-2370
New England Telephone Service

DENTISTRY FOR ALL 800-342-8747
For low-income individuals, provides listing of dentists who have agreed to provide some basic services at discounted fees.

DISABILITY ADVOCATES

INFORMATION CENTER FOR INDIVIDUALS WITH DISABILITIES (ICID)
Voice/TTY 800-462-5015

MASS. OFFICE OF HANDICAP AFFAIRS 800-332-2020

DISABILITY LAW CENTER 617-723-8455

DISCRIMINATION

MASS. COMMISSION
AGAINST DISCRIMINATION 617-727-3990

ELDER LOCATOR SERVICE FOR USA

800-243-4636

Locates the Information and Referral specialist on elder service providers in every state.

ELDERS AT RISK PROGRAM

Social workers can investigate reports of elders who are at risk of self neglect that may cause problems with maintaining bill paying, personal hygiene, home safety, housekeeping, and more.

Contact via the local Home Care Corporation

1. _____

2. _____

EXECUTIVE OFFICE OF ELDER AFFAIRS

617-727-7750

FOOD STAMP HOTLINE

800-645-8333

Answers questions about food stamp eligibility and mails out applications.

HOME CARE CORPORATION(S)

Provide information and referral; case management for home based supportive services for frail elders; protective services; homemakers; Meals on Wheels; pre-admission nursing home screens; personal care attendants; respite programs; housing information; and more. There are 27 home care corporations in Massachusetts.

1. _____

2. _____

HOME HEALTH AGENCIES - MEDICARE CERTIFIED

1. _____

2. _____

3. _____

4. _____

HOSPICES - MEDICARE CERTIFIED

1. _____
2. _____
3. _____
4. _____

LEGAL SERVICES

LOCAL ELDER LAW PROJECT - _____

MASS. BAR ASSOCIATION LAWYER REFERRAL 617-542-9103

MASSACHUSETTS MEDICARE ADVOCACY PROJ. 800-323-3205

MAYOR'S HEALTH LINE (multi-lingual) (Boston) 617-534-5050
(Massachusetts) 800-847-0710

Provides general information on health care coverage options, especially for low-income or uninsured persons. Provides services to all Massachusetts callers.

OMBUDSMEN PROGRAMS - _____

Nursing home and rest home residents' advocate

handles long term care issues of nursing home and rest home residents, including: information about selecting and evaluating nursing homes, payment, levels of care and admission policies; complaint handling and problem resolution; and legal rights of nursing home residents.

PROTECTIVE SERVICES TO HANDLE CASES OF ELDER ABUSE

Elder abuse can be in the form of physical, emotional or sexual harm, neglect, or financial exploitation of an elder aged 60 and older. These injuries can be caused by actions or failures to act.

1. 24 HOUR STATE-WIDE HOTLINE 800-922-2275

2. LOCAL CASE WORKERS - (at Home Care Corporation - _____)

THE RIDE - MBTA

617-722-5123

Door to Door transportation for persons unable to use standard public transportation due to a disability which will last for at least 6 months.

UNITED WAY INFORMATION AND REFERRAL

617-482-1454

Information and Referral Line of All Human Service Needs

OTHER IMPORTANT NUMBERS:

SHINE Counselors in my Region:

REFORMAT EACH YEAR WITH UPDATED INFORMATION AND HEADINGS

name=telephon.srm

09/09/96

**The Commonwealth of Massachusetts
Executive Office of Elder Affairs**

SHINE - Serving Health Information Needs of Elders - Program

One Ashburton Place, 5th Floor

Boston, MA 02108

Tel: 1-800-882-2003 or (617) 727-7750

To Locate A SHINE Counselor In Your Local Area, Find the Area Number for your Town on the Index of Towns and then Match the Area Number with this List of Regional SHINE Programs.

Area #	Regional Program	SHINE Coordinator	Telephone
01	Berkshire County	Lydia Boynton	800-974-4055
02	Franklin/Hampshire County	Joann Lutz	800-498-4232
03	Springfield/Hampden Co.	Gail Noe	800-307-4463
04	Worcester County	Sharon McKenzie	800-244-3032
05	Framingham/Metro West	Pam LeFrancois	800-287-7284
06	Foxboro/Canton	Peggy McDonough	800-462-5221
07	Danvers/North Shore	Sara Bronstein	800-598-1122
08	Minuteman/Burlington	Cynthia Phillips	617-272-7177
09	Greater Lawrence/Lowell	Elaine Rotolo	800-892-0890
10	Malden/Chelsea	Holly Kisler	617-324-7705
11	Needham/Lexington	Maura Walsh	617-964-5009
12	Quincy/South Shore	SHINE Coordinator	617-376-1247
13	City of Boston	SHINE Coordinator	617-635-3995
14	Martha's Vineyard	Marilyn "Sam" White	508-693-4120
15	Plymouth County	Steve Perchard	800-231-1155
16	Attleboro/Fall River	Marion Aspinall	800-987-2510
17	New Bedford	Carolyn Avery	508-999-6400
18	Cape Cod/Nantucket	Beth Fletcher	800-334-9999

SHINE PROGRAM
INDEX OF AREA NUMBERS AND TOWNS

(Find the city you live in and its area. Then look up the Regional SHINE Program from the list.)

<u>Area #</u>	<u>City / Town</u>	<u>Area #</u>	<u>City / Town</u>	<u>Area #</u>	<u>City / Town</u>	<u>Area #</u>	<u>City / Town</u>
15	Abington	02	Buckland	18	Eastham	02	Hawley
08	Acton	08	Burlington	02	Easthampton	02	Haydenville
17	Acushnet			06	Easton	02	Heath
01	Adams	08	Cambridge	14	Edgartown	12	Hingham
03	Agawam	06	Canton	01	Egremont	01	Hinsdale
01	Alford	08	Carlisle	02	Erving	12	Holbrook
13	Allston	15	Carver	07	Essex	04	Holden
09	Amesbury	18	Centerville	10	Everett	05	Holliston
02	Amherst	02	Charlemont			03	Holyoke
09	Andover	13	Charlestown	17	Fairhaven	04	Hopedale
08	Arlington	04	Charlton	16	Fall River	05	Hopkinton
04	Ashburnham	18	Chatham	18	Falmouth	04	Hubbardston
04	Ashby	09	Chelmsford	04	Fitchburg	05	Hudson
02	Ashfield	10	Chelsea	02	Florence	12	Hull
05	Ashland	01	Cheshire	01	Florida	02	Huntington
02	Athol	03	Chester	06	Foxboro	18	Hyannis
16	Attleboro	02	Chesterfield	05	Frammingham	13	Hyde Park
04	Auburn	03	Chicopee	04	Franklin		
06	Avon	14	Chilmark	16	Freetown	07	Ipswich
04	Ayer	01	Clarksburg			13	Jamaica Pla
		04	Clinton	04	Gardner	15	Kingston
18	Barnstable	12	Cohasset	14	Gay Head		
04	Barre	02	Colrain	09	Georgetown	15	Lakeville
01	Becket	08	Concord	02	Gill	04	Lancaster
08	Bedford	02	Conway	07	Gloucester	01	Lanesborough
02	Belchertown	02	Cummington	02	Goshen	09	Lawrence
04	Bellingham			17	Gosnold	01	Lee
11	Belmont	01	Dalton	04	Grafton	02	Leeds
16	Berkley	07	Danvers	02	Granby	04	Leicester
04	Berlin	17	Dartmouth	03	Granville	01	Lenox
02	Bernardston	11	Dedham	01	Gr. Barrington	04	Leominster
07	Beverly	02	Deerfield	02	Greenfield	02	Leverett
09	Billerica	18	Dennis	04	Groton	11	Lexington
04	Blackstone	16	Dighton	09	Groveland	02	Leyden
03	Blandford	13	Dorchester			11	Lincoln
13	Boston	04	Douglas	02	Hadley	08	Littleton
18	Bourne	11	Dover	15	Halifax	03	Longmeadow
09	Boxboro	09	Dracut	07	Hamilton	09	Lowell
08	Boxborough	04	Dudley	03	Hampden	03	Ludlow
04	Boylston	09	Dunstable	01	Hancock	04	Lunenburg
12	Braintree	12	Duxbury	15	Hanover	07	Lynn
18	Brewster			15	Hanson	07	Lynnfield
15	Bridgewater	13	East Boston	04	Hardwick		
13	Brighton	15	E. Bridgewater	08	Harvard	10	Malden
15	Brockton	04	E. Brookfield	18	Harwich	07	Manchester
04	Brookfield	03	E. Longmeadow	02	Hatfield	16	Mansfield
11	Brookline	15	East Wareham	09	Haverhill	07	Marblehead

<u>Area #</u>	<u>City / Town</u>	<u>Area #</u>	<u>City / Town</u>	<u>Area #</u>	<u>City / Town</u>	<u>Area #</u>	<u>City / Town</u>
17	Marion	02	Northfield	01	Savoy	11	Waltham
05	Marlborough	16	Norton	12	Scituate	02	Ware
12	Marshfield	12	Norwell	16	Seekonk	15	Wareham
14	Martha's Viney.	06	Norwood	06	Sharon	04	Warren
18	Mashpee			01	Sheffield	02	Warwick
13	Mattapan	14	Oak Bluffs	02	Shelburne	01	Washington
17	Mattapoissett	04	Oakham	05	Sherborn	11	Watertown
08	Maynard	02	Orange	04	Shirley	05	Wayland
06	Medfield	18	Orleans	04	Shrewsbury	04	Webster
10	Medford	01	Otis	02	Shutesbury	05	Wellesley
04	Medway	04	Oxford	02	South Deerfield	18	Wellfleet
07	Melrose			16	Somerset	02	Wendall
04	Mendon	03	Palmer	08	Somerville	07	Wenham
09	Merrimack	04	Paxton	13	South Boston	04	West Boylston
09	Methuen	07	Peabody	12	South Braintree	15	W. Bridgewater
15	Middleborough	02	Pelham	17	So. Dartmouth	04	West Brookfield
02	Middlefield	15	Pembroke	02	South Hadley	09	West Newbury
07	Middleton	04	Pepperell	02	Southampton	13	West Roxbury
04	Milford	01	Peru	05	Southborough	03	W. Springfield
04	Millbury	02	Petersham	04	Southbridge	01	W. Stockbridge
02	Millers Falls	02	Phillipston	03	Southwick	14	West Tisbury
04	Milleville	01	Pittsfield	04	Spencer	18	West Yarmouth
06	Millis	02	Plainfield	03	Springfield	05	Westborough
12	Milton	06	Plainville	04	Sterling	03	Westfield
02	Monroe	15	Plymouth	01	Stockbridge	09	Westford
03	Monson	18	Pocasset	10	Stoneham	02	Westhampton
02	Montague	18	Provincetown	06	Stoughton	04	Westminster
01	Monterey			08	Stow	11	Weston
03	Montgomery	12	Quincy	04	Sturbridge	16	Westport
01	Mt. Washington			05	Sudbury	06	Westwood
		12	Randolph	02	Sunderland	12	Weymouth
07	Nahant	16	Rayham	04	Sutton	02	Whately
18	Nantucket	07	Reading	07	Swampscott	04	Whitinsville
05	Natick	16	Rehoboth	16	Swansea	15	Whitman
11	Needham	10	Revere			03	Wilbraham
01	New Ashford	01	Richmond	16	Taunton	02	Williamsburg
17	New Bedford	17	Rochester	04	Templeton	01	Williamstown
04	New Braintree	15	Rockland	09	Tewksbury	08	Wilmington
01	New Marlborou.	07	Rockport	14	Tisbury	04	Winchendon
02	New Salem	13	Roslindale	03	Tolland	08	Winchester
09	Newburyport	02	Rowe	07	Topsfield	01	Windsor
11	Newton	09	Rowley	04	Townsend	10	Winthrop
01	North Adams	13	Roxbury	18	Truro	08	Woburn
09	North Andover	02	Royalston	02	Turners Falls	04	Worcester
16	North Attleboro	03	Russell	09	Tyngsborough	02	Worthington
04	N. Brookfield	04	Rutland	01	Tyringham	06	Wrentham
18	North Chatham						
16	North Dighton	07	Salem	04	Upton	18	Yarmouth
10	North Reading	09	Salisbury	04	Uxbridge		
02	Northampton	01	Sandisfield				
05	Northborough	18	Sandwich	07	Wakefield		
04	Northbridge	07	Saugus	06	Walpole		

Rev: 7/12/96



